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SOLITUDE

Laugh, and the world laughs with you,
Weep, and you weep alone;
For the sad old earth must borrow its mirth,
But has trouble enough of its own.

Sing, and the hills will answer,
Sigh, it is lost on the air;
The echoes bound to a joyful sound,
But shirk from voicing care.

Rejoice and men will seek you;
Grieve and they turn and go;
They want full measure of all your pleasure,
But they do not need your woe.

Be glad and your friends are many;
Be sad, and you lose them all,
There are none to decline your nectar'd wine,
But alone you must drink life's gall.

Feast, and your halls are crowded;
Fast and the world goes by;
Succeed and give, and it helps you live,
But no man can help you die.

There is room in the halls of pleasure
For a large and lordly train,
But one by one we must all file on
Through the narrow aisles of pain.

—ELLA WHEELER WILCOX.

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The Southern Surgeon

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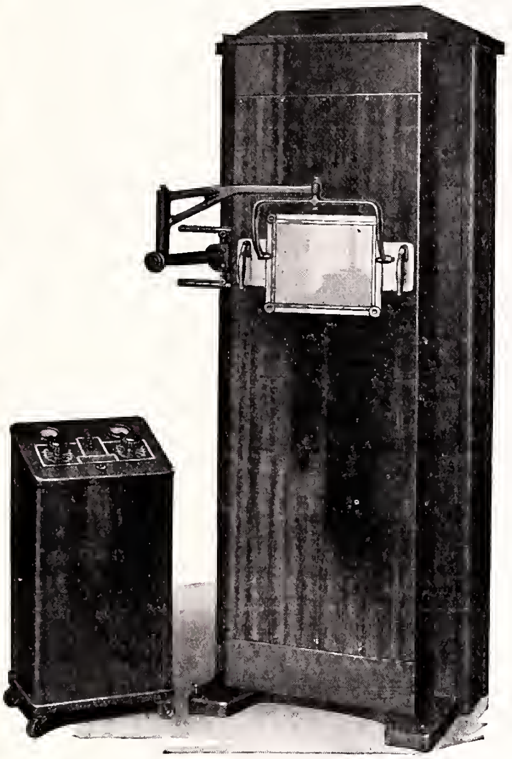

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No man can build a very high structure on some one else's demerits.

Preventive medicine is a problem for the entire profession, not just the county health officers.

We appreciate the paper by Drs. Warr and Gotten on Undulant Fever. They are men who speak with authority.

We are glad to have a discourse from the pen of Dr. Seale Harris of Birmingham. We are always glad to have anything from his pen.

Help us increase the subscription list of The Mississippi Doctor. One dollar for one year in clubs of five or if you subscribe this month. The Mississippi Doctor has a mission. We cover the field of medicine and surgery with papers from men who know. It is readable. It is dependable. It is the champion of The Community Hospital.

Examine your patient from the top of his head to the bottom of his feet, every one of them. Keep up the spirit. Be persistent. Keep on keeping on. You are a part of a great profession. Do not get stale on the job. It is not so much what you do not know, but what you do not do that keeps you from being distinguished in the profession.

The North East Mississippi 13 County Medical Society holds the banner for the community hospital. Watch this society set the example for the United States in bringing modern medicine to the masses at a reasonable price.

Dr. J. G. Mancil has given us a good paper on tonsillitis. Tonsillitis we have with us always. This paper was read before the Delta Medical Society over on the banks of the Father of Waters. Dr. Mancil constitutes one of the many very able professional men in this society.

Let every one go to Amory next Tuesday and do honor to one who has done much for the medical profession in our state, one who emenates a fine medical spirit, one who is a great student and one who has a great vision of the possibilities for service of the medical profession.

During the storm the Aberdeen Hospital took care of forty six victims without one cent cost to any patient. This was a noble piece of work. Some were able to pay, but they had met misfortune in this great cyclone. The people of Aberdeen paid the hospital expense and the doctors did the work without charge. This was a noble piece of professional religion. We commend the medical profession and the citizenry of Aberdeen, that distinguished little city of Southern culture and refinement.

Dr. G. P. Sanderson of Vicksburg has a splendid paper on Pyelitis in this issue of the journal for which we thank him.

The outstanding problem for the gynecologist is to diagnose the potential cancer case and apply his prophylactic treatment.

We are glad to have the able paper on Diabetes by Dr. Henry B. Gotten of the Polyclinic. This is an able paper. He speaks authoritatively.

The North Mississippi Seven County Medical Society rendered a fine program at Holly Springs on Wednesday evening, June 15th. This society puts up a good program each time. It is growing better all the time. It is doing much good in helping to look after our medical department at Ole Miss. We are always glad to attend this this society. The president for this year is Dr. H. P. Boswell. He is doing the job with ease, dignity and efficiency. Dr. A. H. Little is the very efficient secretary. He would do honor to any medical association in the state or out.

No man needs to be so broadly educated as the practising physician, none so versatile. To know the technic of an operation or prescribe a pill does not answer that demand of today. Some working knowledge of psychology and psychiatry is of the greatest importance at this time. If every man has his price in politics, every man is a little crazy under such financial stress and strain as we are now having. People are not their normal selves. They are often undecided as to whether they will try to buck the line and go forward and longer. They are smarting under the load of debt and the worry and embarrassment it brings. Suicidal intent is in the mind of many and brighter outlook is so impossible. Some have an idea that their insurance is worth more to their families, would be, than they can possibly be. The many "spontaneous" fires are evidences in some cases that the honest working spirit in the man has been over come. The times are calling for men with a broad vision, a sympathetic heart, and a courageous soul overflowing with faith for the future. The human organism must have outward adjustments as well as inward medication and surgical plumbing. To give courage we must be courageous. To inspire hope we must be full of hope for a better day in the future. We must be a friend in deed to a clientel who is surely in need of many of the essentials of life in this time of stress. No other man carries the heavy responsibility today that the practitioner is carrying, no other profession has such an opportunity. Let us catch the vision and do the job in a big and successful manner. Let us do it with courage and with an optomistic and cheerful spirit. Service to your fellow man can not be wasted.

Dr. J. A. Rayburn and son Dr. T. H., are now located at Pontotoc. We welcome them back to our society and predict for them success in this field.

The well trained nurse is the axle to the medical profession. The good physician who utilizes her services co-operatively will soon roll up the hill to success.

There is no one thing common or of small importance in the medical profession. We need men who are experts in the application of the known medical truths.

The practising physician must now make his profit on volume of business rather than a long price to the individual patient. Henry Ford sells the cheapest car, but he has made the most money.

Anti-Rabies treatment is now furnished by the state board of health for two dollars and fifty cents. It is good service to the people to be able to get it at this price.

Our people must be taught to give little gifts to the small hospitals. It will not leave them poor, but it will enable the small hospital to give good service on a two or three dollar a day room rate.

It appears to us that some small hospitals were left off the list by the legislature that should have been on. The aid was small to each one, but we regret that any deserving ones should have been left off. It was not the fault of the hospital committee. The bill that finally passed was not our bill although it contained many of the provisions we advocated. The bill was rushed through at the very last hour and some were just overlooked we presume.

Fred W. Duckworth finished his term as president of the Mississippi State Pharmacy Association with the closing of the annual session at Natchez last week. His presidential address received much favorable comment by the local press of that distinguished and cultured city. The state association of pharmacist did itself an honor in bestowing its highest gift on Fred W. Duckworth. He is not only one of the most competent pharmacists in Mississippi, but he is much more, he stands in our highest rank as a fine type of citizen. In discussing the problems of the associated pharmacists in Mississippi, Mr. Duckworth frequently used the key words, the Golden Rule Phrase, "Live and Help to Live." If the Republicans could have struck such a keynote the party would have had some chance to win. No words could have been more timely than these just now. It is not enough to live and let live, "Live and Help Live," make your own living and in addition do a little extra and help some one else to live.

If we would only do this hard times would vanish like a ghost at the rising of the sun. There are a million ways to live and help to live before we take any action on the 18th amendment. Let Uncle Sam teach his people to make an honest living by giving service for every penny received and then do a bit extra to help the unfortunate who at times can not help himself and we would soon be a happy and a prosperous people. It is a pity that those wet bawling Republican hood-lums in Chicago could not have heard Mr. Duckworth's address and their brains could have been dry enough to have caught its vision. If the association appropriates the "keynote" of President Duckworth's address its increasing influence in our social economy will soon be felt in our state. The pharmacists constitute a great profession and one whose services are being recognized and appreciated more and more. The pharmacist is the power behind the throne to many a successful practitioner. He constitutes a very important part of the medical profession in reality. Our town is doubly blessed with efficient pharmacists and a fine type of pharmacy citizenry. We congratulate F. W. Duckworth on this splendid address and we recommend to his profession, to our profession and to the political parties of our nation his keynote, "Live and Help to Live.

Thirty-five small hospitals are to receive thirty-nine thousand dollars a year from the state for charity patients. It is not to be paid in a lump sum, but to be paid on an itemized and approved account of each patient. This is as it should be. The hospitals receiving this aid must first be approved by a board of three, one appointed by the president of the state medical association, one the president of the hospital association, and one by the president of the state nurses association. This board is composed of the following respectively, Dr. C. M. Speck of New Albany, Mr. Hamilton Crawford of Hattiesburg, Miss Dorsey R. N. of Greenville. This board will check the thirty-five hospitals listed by the state legislature at once. They are to receive only five dollars per day while doing this work and each hospital is to be assessed ten dollars to pay these expenses. This is a good plan and this is a good board. The Governor is to appoint three trustees for each hospital to approve the applicants applying for charity and to O K the bills. Two dollars per day are allowed for charity patients in wards with necessary incidentals added. This is not the bill that was sponsored by the committee selected by the medical association, but it does have many of the features of it. The amount for the small hospitals over is very meager. But we should accept it in good spirit and use it to the very best advantage of the poor people who are so much in need at this time. Let us make it the strong evidence of our bigger and better plans for the future.

Undulant Fever

A Brief Report of Seven Cases

BY OTIS S. WARR, M.D., AND
HENRY B. GOTTEN, M.D.
THE POLYCLINIC
Memphis, Tenn.

Undulant fever, an old disease only recently recognized as common to man, has become so widespread that it is fast becoming a major public health problem in all sections of the country. Prior to 1925, the disease was recognized only in goat raising districts and only 128 cases had been reported. By January, 1930, the number had grown to 2,365, tabulated from the health departments of all states of the Union, although in some states undulant fever is not a reportable disease. Of this number, 190 were in the Tri-States. Before 1928, 38 cases had been recorded in Tennessee, and 2 in Mississippi. In 1929, 89 were recorded in Tennessee, 9 in Mississippi, and 2 in Arkansas. Of the series which we present, 3 were from Memphis, 2 from Mississippi, and 2 from Arkansas.

Cattle and hogs seem to be the chief sources of infection in this country. The ingestion of the organisms through raw dairy products, particularly cow's milk, is the principal mode of infection. The skin, as well as the digestive tract, may be a portal of entry. As a result of direct contact with infected animal tissue, packing house workers, handlers of meat, farmers, and veterinarians are often affected by the disease. The incubation period seems to be from four to sixteen days.

The age distribution apparently is dependent upon a variation in susceptibility and direct exposure to infected animals. The relative immunity of children, the principal milk consumers, appears to be parallel to the immunity in calves. The sexes are infected about equally.

Undulant fever often presents a wealth of symptoms and a dearth of physical signs. The onset is usually gradual and insidious. Weakness, general malaise, headache and backache, and anorexia may precede or accompany fever, chills, sweats, and pains in the joints and extremities. Less frequent symptoms are nausea, vomiting, dizziness, bronchitis with cough and sore throat, and sore gums and teeth. Often the patient is not incapacitated by his illness, although his temperature may be surprisingly high. He may feel quite well in the morning, but as the temperature becomes elevated the symptoms return, and nocturnal febrile exacerbations may be severe.

The clinical picture varies greatly and often is so indefinite as to obscure the diagnosis. Careful differentiation must be made between typhoid fever, influenza, malaria, tuberculosis, and, less frequently, rheumatic fever and endocarditis. To confirm a clinical diagnosis, laboratory tests are necessary. The agglutination test is the best diagnostic agent, but a negative test does not exclude undulant fever or a positive test necessarily imply that the patient has the disease.

The most distinctive feature of the clinical course is the fever. It may be the rare and usually fatal fulminating type, or the undulant or continued type which may persist for weeks or months. The majority of cases are of the continued type. Chills, which sometimes are very severe, are often as constant as the fever, and may recur daily at the same time. Sweats may be mild or profuse. Headache, backache, arthralgia, muscular pains, and neuritis may appear early or late. Asthenia, loss of weight, and, in prolonged cases, anemia are almost constant findings.

Undulant fever may last only a few weeks or months or may persist for years. The average duration is about four months. The height of the agglutination titre bears some relation to the prognosis, since recovery has been most rapid in those cases in which the agglutination titre has been very high.

The treatment is essentially symptomatic. Reports of the various investigators on the efficacy of vaccines are, in general, favorable, but as yet there is no controlled basis for recognition of these products. The various dyes, used intravenously, have not given uniform results.

The 7 cases in our series varied from the mild to the severe in type. Their duration was from one to twenty months. Three patients were men and four were women. The age distribution ranged from 29 to 46 years. Brucella Abortus was uniformly the causative agent. Fever, sweats, muscular pains, and aching of the limbs and joints were constant symptoms. In every case fever was consistently of the intermittent type.

Two patients had a similar type of the disease, both being mild. These were women, aged 43 and 45. Both complained of irregular fever, chills, and aching of the limbs and joints. The agglutination tests were positive in dilutions to 1:640. Their symptoms disappeared and fever subsided in about one month.

The second case was more severe. The symptoms were intermittent fever preceded by aching and pains in the extremities. The agglutination test was positive in dilutions to 1:640.

A fourth patient also complained of chills and fever. The agglutination test was strongly positive. When she consulted us fever was recurring, but physical examination revealed only a normal pregnancy. The febrile period lasted a short time and the pregnancy terminated normally.

The fifth patient suffered more than three months from intermittent fever, chills, sweats, aching of the muscles, and nycturia. The agglutination test was positive in dilutions to 1:-2560. Blood cultures were also positive. Two months after the diagnosis was made the patient was still running a temperature.

The two most severe cases were of patients from Arkansas. Both complained of fever, chills and sweats, with the maximum temperature ranging from 101 to 104 degrees. The only other symptoms were slight burning on urination and arthralgia. Physical examinations of both were negative. The agglutination tests were positive up to 1:1280. For a period of five or six months from the onset alternate febrile and afebrile periods of approximately two weeks duration continued.

This report of seven cases does not warrant any conclusive data, but does call attention to the presence of undulant fever in the Tri-States.

Some Fundamentals of the Diagnosis and Treatment of Diabetes Mellitus

BY HENRY B. GOTTEN, M.D.
THE POLYCLINIC
Memphis, Tenn.

Diabetes mellitus is a disease which comes under the observation of physicians in all branches of medicine. Owing to the increasing number of cases seen and the complications they present, it is one of the most important diseases of which we know. The treatment must be based on a number of factors, and for this reason care should be exercised to avoid diagnostic errors. Some of the more common of these errors, as well as a few fundamental points in treatment will be discussed here.

As a rule, in the diagnosis of diabetes, too much reliance is placed on the results of the urine analysis. We assume that a patient has diabetes because sugar is found in his urine. On the other hand, we falsely assume that he does not have diabetes if a specimen of urine does not contain sugar.

The error of the first assumption is possible if we fail to regard a low renal threshold, emotional disturbances, hyperthyroidism, and cerebral lesions as possible factors in the production of glycosuria. In the second instance, the error comes about because we neglect to consider that the specimen of urine examined may have been voided when the blood sugar was below the renal threshold and therefore did not spill sugar into the urine. This is particularly true in cases of high renal threshold, some of which are as high as 300 mg. In other cases, the blood sugar recedes during the night, and if the specimen is obtained before breakfast, we are led to the erroneous conclusion that the patient does not have diabetes. Further, the symptoms prsented by the patient are often misleading. We have been taught that the cardinal symptoms of the disease are polyuria, polydipsia, and polyphagia, and have failed to recognize the condition unless they were present. These indicate starvation and dehydration, however, and do not occur except in advanced stages. Moreover, many patients with severe diabetes will complain of none of these symptoms except perhaps loss of weight. Again, such signs as increase of appetite, thirst, and polyuria often disappear when acidosis is present.

We should remember also that, although diabetes is a disease which affects elderly persons principally, it is often seen in children. In the latter, the onset may be abrupt; it may follow an acute upper respiratory infection, a contagious disease, or other affections common to childhood. An extreme acidosis, or even a state of coma may characterize the onset.

The diagnosis of diabetes is made on the following clinical and laboratory findings:

(1) Symptoms of polyuria, polydipsia, and polyphagia, sugar in the urine, and a high blood sugar.

(2) Righ blood sugar without the usual symptoms of diabetes, if a sustained glucose curve is obtained.

(3) Symptoms of peripheral neuritis, failing vision, paraesthesia, vertigo, infections over the body, especially about the feet or neck, tinnitus, signs of an arteriosclerosis too advanced for the patient's age, and a glucose tolerance curve indicative of decreased carbohydrate metabolism.

The symptoms in the last group are seen in probably more than 50 per cent of cases. As these patients present themselves early, frequently no sugar is found in the urine and the condition is unrecognized until evidence of severe diabetes is present. Their symptoms are seldom relieved until the diabetes is under control.

The finding of sugar in the urine should never be ignored. If any doubt exists, a tolerance curve should be made to establish definitely the diagnosis of diabetes or show the sugar to be the result of other disturbances.

Despite the fact that the treatment of diabetes has been fairly well standardized, many patients are still being treated incorrectly. Often they are not instructed in the management of the diet; some are cautioned against eating too many sweets; others are told that a moderate amount of sweets is harmless, and that honey may be substituted for sugar; others are advised that meat should be restricted.

The more serious error, however, is failure to utilize insulin to advantage. If insufficient or no insulin at all is given, a reduced carbohydrate diet will not always bring about a lower blood sugar. Physicians are often afraid of insulin because of reactions frequently encountered.

In the use of insulin, it is important to give an adequate amount and to divide it correctly between the three meals. If the blood sugar tends to rise unduly during the night, a midnight dose may be required. The proper dose is arrived at by trial and error, after a sufficient quantity has been given to render the patient free from acidosis. Daily urine sugar examinations after meals, with occasional or frequent blood sugar determinations, as indicated, will guide the physician in finding the correct insulin dose.

Elderly patients with mild diabetes, who have not lost an appreciable amount of weight and show no evidence of acidosis, should not have too vigorous treatment. Although they are generally over weight, arteriosclerotic, and have some myocardial weakness, it is not necessary to rigidly restrict their consumption of carbohydrates. Further, it is often impractical and unnecessary to have the diet weighed. If the renal threshold is normal, they should be put on a diet which only moderately limits carbohydrates and fats. By this means they should gradually reach a satisfactory weight. A moderate restriction will generally suffice, also, to render them free of symptoms and to maintain the blood sugar at a normal level. Both weight and blood sugar should be checked at intervals, as it is never well to allow these patients to assume they are free of the disease.

In the more severe cases of diabetes, greater care is imperative. These patients may be young or old, and may or may not have acidosis. Their loss of weight is usually excessive. As they require meticulous attention, they should be sent to a hospital, where proper dietary control can be exercised and accurate blood sugar determinations made. They should be placed at once on a diet containing a balance between the carbohydrates, fats, and proteins. The carbohydrates need not be too strictly limited. From 100 to 150 grams a day are allowable, as the diet will thus be more palatable and the patient more likely to follow it. Patients are reluctant to follow diets too low in carbohydrates. A preliminary starvation or basal diet is contraindicated. Such a procedure tends to prolong hospitalization and make treatment more difficult, as the diet must be changed several times and the insulin dose readjusted each time the diet is changed. If the diet is stationary, only the insulin dose requires adjustment.

During hospitalization the patient must be taught how to weigh and measure his diet carefully, to sterilize a syringe, and to measure and inject insulin. He should be taught how to examine his urine and how to increase or decrease the insulin if sugar appears in the urine, or if he suffers insulin shock. He should be informed of the principles concerning diabetes, as well as its complications. He should also be instructed to see his physician at regular intervals for the proper changes in diet and insulin, or in case any complications arise. Too often, after being standardized, a patient is turned loose to look out for himself, and feeling that the physician has no more interest in him, he neglects his treatment.

The treatment of patients in coma is relatively simply if we remember a few points. Large doses of insulin, of 30, 40, or 50 units.

should be administered every two hours until some response is obtained. Meanwhile, close watch must be kept on the blood sugar. If blood sugar determinations cannot be obtained, frequent tests of urine should be made. As soon as the urine is sugar free, large amounts of glucose in the form of orange juice should be given until the patients are out of coma. Heat, fluids, and stimulants are useful adjuncts in restoring consciousness; it is doubtful that alkalies are of any benefit. Proper measures for control can then be instituted.

Insulin shock following treatment for coma is combated by the administration of adequate amounts of glucose. It should not be confused with a relapse of the coma.

Surgery in diabetes is meeting with remarkable success when combined with treatment by competent internists. By this method, diabetics, who are so frequently in need of surgical treatment, can be handled with little risk. They must be given individual attention, based on the complications present. Preliminary measures, the decision when to operate, the type of operation, the choice of anesthesia, and post-operative treatment must each receive due consideration. With proper care throughout, the results of surgery on diabetic patients should be as gratifying as on non-diabetic patients.

The treatment of diabetes mellitus should be adjusted to the patient, rather than the patient to the treatment. Patients present themselves in all stages of the disease, with numerous and varied complications, all of which should be given careful thought before treatment is begun. Over-treatment may be as harmful as under-treatment.

CONCLUSION

1. The diagnosis of diabetes is not always simple, but it should be established definitely before treatment is instituted.

2. Diabetes should be suspected in patients who complain of apparently inconsequential symptoms. It should not be overlooked in children.

3. Complications occurring in diabetes should be handled promptly, with precision and accuracy.

4. The patient should be properly instructed in the principals of diabetic treatment.

5. A close relationship and understanding should be established and maintained between the physician and patient which will keep the patient in contact with the physician at frequent intervals.

6. Diabetes is not a contra-indication to surgery if properly understood and treated.

7. The results of diabetic surgery are best when the internist and surgeon work together.

8. Treatment should be adjusted to the individual case.

The Relation of Gastric and Renal Disorders

BY SEALE HARRIS, M.D.
Birmingham, Ala.

Among the papers of interest to the general practitioner read at the recent meeting of the American Medical Association in New Orleans was one by Friedenwald and Morrison[1] entitled "Clinical Observation on the Relation of Gastric and Renal Disorders." It is the general practitioner who first sees the patient with early manifestations of failing kidney function; and in such cases if he recognizes that the anorexia, vague abdominal discomfort, nausea, vomiting and diarrhoea, and sometimes obstinate constipation are due to metabolic changes of renal origin, he can institute treatment that may prevent irreparable damage to the kidneys and myocardium. If he fails to make the correct diagnosis in such a case, and treats the symptoms as of primary gastro-intestinal origin, allowing his patient to become dehydrated and toxic from retained urinary products, his trusting patron is doomed to an early death from uremia or a damaged myocardium.

In the discussion on Friedenwald and Morrison's paper it was brought out that in any case of nausea and vomiting, with either constipation or diarrhoea in a man or woman past fifty, in which symptoms cannot be accounted for otherwise, it is safest to consider that they are due to renal dysfunction and treat the patient accordingly. The prompt aministration of sufficient fluids and soluble carbohydrates in such cases saves lives. If the patient cannot retain water and soluble carbohydrates such as orange juice, lemonade, orangeade, dextrose (cane sugar), glucose (corn syrup) solutions, and coffee or tea, at least three or four quarts a day, fluids and dextrose may be given by hypodermoclysis (five per cent solution) or intravenously (ten per cent solution). If there is constipation plain water may be given by proctoclysis after a cleansing enema. It is futile, and even harmful to give glucose or other carbohydrates per rectum, (deTakats,[2] Harris[3]). In cases of suspected renal damage salt solutions should be given sparingly, not more than 1000 c.c. a day. (Trout)[4] while sufficient fluids should be given it is unsafe to give more than 4000 c.c. a day, because of the danger of "water intoxication," (Roundtree[5]) or of overworking damaged kidneys, or of overwhelming a toxic and failing myocardium.

Of course, it is desirable to make renal function tests (phenolsulphonephthalein), and blood chemistry studies (non-protein nitrogen, urea, creatinin, carbon dioxide combining power of blood plasma, etc.) in such cases to determine the functional capacity of the kidneys and the character and degree of the toxemia; but the general practitioner, who may not have laboratory facilities available, should play safe by treating the patient with gastro-intestinal symptoms of suspected renal origin as if he were positive of the diagnosis of primary kidney disease.

In men past fifty whose first symptoms are anorexia, nausea, vomiting and diarrhoea, unless known to be due to food infection or other demonstrable causes, an examination of the prostate, and the bladder for residual urine, may clear up the diagnosis. Not infrequently the first symptoms of urinary obstruction and retention from an enlarged prostate are nausea, vomiting and diarrhoea, and the patient may be saved from permanent renal and myocardial damage, and an early death, by recognizing the nature of the disease and administering the appropriate treatment. In such cases operation for the relief of the prostatic obstruction should be deferred until all evidences of uremic symptoms have subsided. The toxic patient with gastro-intestinal manifestations of uremia is a bad risk for any kind of a prostatic operation.

Friedenwald and Morrison also discussed renal disease of gastro-intestinal origin, particularly the kidney insufficiency seen in pyloric, or high intestinal obstruction. They stressed the fact that the toxemia, and alkalosis, that are such dangerous complications in neglected duodenal ulcers with pyloric obstruction and gastrectasis, may be associated with renal insufficiency; and that in such cases, prolonged and thorough preparation of the patient for operation will lower the mortality in gastric surgery. Neither the general practitioner nor the specialist should ever lose sight of the very intimate physiologic relation between the kidneys and the digestive system.

1. Friedenwald, Julius, and Morrison, Samuel: Clinical Observations on the Relation of Gastric and Renal Disorders. Read in the section on Gastro-Enterology of the American Medical Association, New Orleans, May 13, 1932.
2. deTakats, Geza: Push fluids, the surgeon's postoperative order. Am. J. Surg. 11:39-44, (January) 1931.
3. Harris, Seale: The futility of glucose enemata. Jour. Med. Assn. Ala. 1, 6:260-261 (Dec. 1931.)
4. Trout, Hugh: Proctoclysis: An experimental and clinical study. South. M. J. 6:791-794, (Dec. 1913)
5. Roundtree, L. G.: Water Intoxication. Arch. Int. Med. 32:157-174. (1923).

Pyelitis*

BY G. P. SANDERSON, M.D.
Vicksburg, Miss.

I feel I should apologize for writing a paper on so trite a subject but it is probably well for all of us at times to give a more detailed study to the commonplace things. It is not unusual to see the commonplace condition overlooked, in our search for the unusual.

Pyelitis is defined by Osler as inflamation of the kidney pelvis and the conditions, which result from it. However, the terms pyelonephritis and pyonephrosis are no longer considered under different headings and are all grouped under the heading of pyelitis. At one time it was thought that lesions invilving only the pelvis (pyelitis) or extending from the pelvis into the kidney (pyelonephritis) were always the result of infection from below, and that the more intense infections (abscess, etc.) were blood borne. Since it has been proven that hemogenic infection may set up a lesion confined entirely to the kidney pelvis, all three conditions are considered under one terminology.

ETIOLOGY—Pyelitis is, the result of the inplantation in the pelvis of bacteria from some focus in the body by ways of the blood stream, or the passage up the ureter of infected material from the bladder, when for some reason the kidney cannot eliminate the infective material. The factors that influence the ability of the kidney to eliminate the infectious material may be general or local. Under the general heading would be considered anemia, some intercurrent disease or malnutrition; under the local causes, displacement of the kidney, nephritis, pressure on the ureter by a possible tumor, kinking of the ureter, etc. We must not forget that occasionally certain drugs taken internally set up an inflammatory condition in the kidney pelvis. Of these turpentine is probably the outstanding example.

SYMPTOMS—The patient with acute pyelitis gives the picture of any acute general infection, with only pain over the kidney to identify the disease, Intermittent chills and fever with sweats together with pain over one or both kidneys will usually make the diagnosis. The pain may be dull aching in character or may later, during the passage of a mass of pus cells, closely simulate renal colic. The urine will show a few pus and blood cells; may be either acid or alkaline, depending on the infecting organisms; and the albuminuria due probably to the presence of the blood cells, is usually of a higher grade than the pyuria. As the condition becomes more chronic the general symptoms persist and pyuria becomes more pronounced. In addition there generally then appear the symptoms due to irritation of the lower tract, namely, frequency, burning, disuria, urgency, difficulty, or tenesmus. Fever is almost always present; pyuria is constant and most always present; pyuria is constant and even with the absence of pus in the urine, it must be remembered that the pyelitis may be confined to one side and the ureter of that kidney temporarily blocked and thus no pus appear in the urine at the time of examination.

Polyuria is an indication of renal damage and is often associated with partial or intermittent obstruction. Tumor may or may not be noted.

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*Read before the Issaquana-Sharkey-Warren Counties Medical Society, Vicksburg, Miss., June 14, 1932.

DIAGNOSIS: In diagnosis the following points must be determined:

(1) The identy of the infecting organism.

(2) The source of the infection.

(3) The severity and extent of the lesion.

(4) The amount of damage done to the secreting renal parenchyma, and

(5) Whether obstruction is present and if so its cause.

The examination of the urine is of paramount importance. Low specific gravity indicated renal damage and a strongly alkaline, ammonical urine indicates an infection with urea-splitting organisms. Albumin is of minor value, as its presence may be due to other causes. The presence of bacteria is proof positive that infection exists somewhere in the urinary tract. If cocci are found a gram stain should be made and if bacilli are found appropriate efforts at eliminating the possibility of tuberculosis should be employed, even to the injection of a guinea pig in doubtful cases.

CYSTASCOPY is indicated subject to the condition of the patient. By this means many important facts are elicited, i. e. whether or not there is a cystitis and if so whether it is primary or secondary, whether one or both kidneys are involved, and the respective functions of the kidneys, as well as a general examination of the bladder for calculus, obstruction, tumor, etc. X-ray examination made possible by the cystoscope may give valuable additional information. In this connection I may say that sodium bromide solution seems still to be the most effective media for pyelography though lipsiodol, gives a beautiful outline of the tract. The main object to the latter is the difficulty of injecting it through small catheters. The various preparations used intravenously are usually not satisfactory for definate pelvis outline though they are of some value.

TREATMENT: Remove the cause, often times more easily said than done. The elimination of all possible foci, the correction of mechanical abnormalities and the treatment of the condition itself. Fluids should be taken freely, particularly alkalies. Urinary antiseptics are of some value. Personally, I have found pyridium tablets very effective. Vaccine therapy gives good results in some cases but lavage of the kidney pelvis with some weak silver preparation seems to be most beneficial in the general run of cases. The general treatment of the patient is the same as for any other condition, i.e., tonics, nourishing food, milk in abundance and above all things fluids.

References: Osler; Hugh Young.

Tonsillitis*

BY DR. J. G. MANCIL
Indianola, Miss.

This subject, upon which I wish to talk, is one which is such a common malady that it seems nothing further can be said about it.

What can one say concerning tonsillitis? Tonsillitis is any inflammatory process involving the tonsils and often extending to adjacent structures. This group of diseases may, for convenience, very well be considered under five heads, namely: acute tonsillitis, chronic, streptococcus, sore throat, Vincent's angina, pertitonsillar abscess or quinsy. I will discuss each separately. Acute Tonsillitis is an acute infectious disease characterized principally by an inflammatory process involving the tonsils and often extending to adjacent structures. This disease is extremely common, practically all ages affected. It is relatively rare in infancy and old age. It is most frequently found during childhood and early adult life, and becomes less common as old age approaches. The frequency which the disease is found will be largely influenced by the care exercised in making routine examinations. This applies practically to young children who are not able to make complaint as to the location of pain. Very often, even with adults, considerable involvement may be present without sufficient discomfort to cause the patient to mention the symptoms if particular inquiry is not made. Tonsillitis is of much importance, not only from the amount of actual temporary discomfort entailed, but also on account of the many possibilities of trouble. Acute tonsillitis may be transmitted by any means that causes an individual to come in contact with infected secretions from the mouth of a patient. It is highly probably that the disease is often conveyed by the use of public drinking cups and improperly cleaned drinking and eating utensils; it may also be conveyed by kissing, exposure to cold and, no doubt, may result from the same general cause as colds. The most common organisms responsible for this disease are the streptococcus, staphyloccus and pneumococcus. The most important symptoms of this condition are chilliness or rigors, temperature usually very high, 103 to 104, and in some instances higher, pain almost constant in the beginning, general aching, especially head, back of neck and lower extremities; nausea is not a constant symptom but is often seen in early stage, and a factor that is probably responsible is the excessive secretion present in many cases; usually there is disinclination to take food, on account of nausea and pain of swallowing. In many cases where there is no anorexia, swallowing may cause such discomfort as to prevent the patient from taking food. The local signs, found upon examination of tonsils, reveal considerable redness and extension to surrounding structures, especially the pillars of tonsils; the tonsils being more or less enlarged and may have deposits in the crypts. These deposits usually have the appearance of spots or white lines, instead of patches. These deposits differ decidedly from diphtheria and Vincent's angina and do not bleed when removed. From a standpoint of differential diagnosis, a culture is invaluable and should be made in all cases of sore throat. In acute tonsillitis, you will invariably find increase in total white count and neutrophil percentage and, in some cases, these changes are very marked. CHRONIC TONSILLITIS is probably more frequent than the general practitioner suspects and a thorough investigation of the tonsils should be an indispensable part of the general examination. Chronic tonsillitis is important largely on account of the possibility of other troubles. A focus of chronic infection in the throat may materially interfere with the patient's well-being from many standpoints. The discovery of this condition depends largely upon the character of investigation made. We are often consulted for ailments that are purely secondary conditions and so often the tonsils are the real focus of infection. The temperature in chronic tonsillitis may be very slight, or no elevation at all; cough is not constant. Very often the focus of infection in the tonsils is a factor in the predisposition of the patient to frequent attacks of colds, especially during the winter months. The cervical glands, in relation to the tonsils, may show more or less enlargement. Upon examination of the throat, the tonsils may be found to be large irregular masses projecting toward the middle line, and often cause mechanical trouble by their presence. On the other hand, it is not unusual to find the tonsil apparently normal in size but, when pressure is made, pus can be squeezed out of the crypts. Usually the breath has an offensive ordor—due to deposits of hard cheesy masses in the crypts.

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*Read before the Delta Medical Society, Cleveland, Miss.

Streptococcol sore throat differs so little from that of acute tonsillitis that it will be covered briefly. Practically all constitutional symptoms are the same. Upon examination of the throat, more or less extensive white membrane will be found. This has a tendency to spread to surrounding structures, often times along roof of mouth until it reaches the upper incisors. If membrane is removed, a bleeding surface is left. The only positive way to differentiate this condition from diphtheria is by culture. Vincent Angina is one of the forms of acute sore throat. Its discussion properly comes under the head of tonsillitis, as the tonsils are most frequently involved. It is a moderately serious disease, requiring careful handling. The characteristic signs are moderate or slight but, at other times, violent pain in swallowing or talking. The onset, with symptoms of subacute or mild tonsillitis, may be malaise headache, chilly sensations, slight fever (102 to 102 1-5) unilateral enlargement of cervical glands, especially in children. Presence of grayish white

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patch or patches in the earlier stages are visible upon the tonsils, most frequent at its upper part, spreading later to the soft palate, the other tonsil, pharynx or the gums. The patches are surrounded by a red inflamed areola but separated from each other by healthy tissue. On removal of the membrane, which is granular and cheesy in consistency, an ulcerative area is exposed which bleeds freely and is soon covered by a new membrane. The membrane may spread like diphtheria and just as quickly. Examination of a stained smear will quickly settle the diagnosis. Microscopic examination of a stained smear showing a fusiform bacillus twice as long as wide, pointed at the ends, in symbiosis with a spirillum forming a network around the bacilli.

Peritonsillar abscess or quinsy is fairly frequent and many patients show a marked tendency to recurrent attacks unless the tonsils are removed. The early constitutional symptims are practically the same as acute tonsillitis, except that this may be more pronounced and persistent. Almost from the beginning, the patient has very anxious expressive voice, greatly impaired due to excessive secretions and swelling. There is almost always considerable swelling externally; swallowing is very difficult and often times there is inability to swallow. Upon examination, considerable redness of tonsils and surrounding tissue will be found; also tonsils swollen and bulging; the swelling also marked above anterior pillars and extending to uvula. The most important symptoms and differential diganosis have been given under each heading; therefore, will not discuss further. There are, however, two other conditions which have not been mentioned in this paper, namely, diphtheria and syphilitic sore throat. These conditions should always be considered and, when in doubt as to the offending infection in any sore throat, a culture is absolutely necessary to clear up the diagnosis. As to treatment, there is no specific treatment for this disease. It is one of those conditions in which much can be done for the relief of suffering, for shortening the course of the disease and limiting complications. General care of patient is necessary. Rest is often neglected, but when we consider the extent to which there is a tendency to involvement of kidneys and heart and other body structures, we are impressed with the necessity for sufficient rest in bed. Drastic purgations not desirable, but sufficient intestinal elimination should be maintained. Light diet—the food given will have to be influenced not only by the temperature but also by the ability of the patient to swallow. Medical treatment is purely symptomatic. We have several objects in view, to produce relief from pain, to modify the course of the disease and to limit the possibilities of complications. My best results are obtained by the use of salicylates, preferably acetyl salicylic acid combined with bismuth subnitrate if there is any tendency to gastric disturbance.

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June 15, 1932

PROGRAM

Invocation by Rev. Golding, Holly Springs.
Dinner, "Dutch"
Business Session
Intermission, Five Minutes
Scientific Section

(1) "Digestive and Infectious Diarrheas in Children" by Dr. D. R. Moore, Byhalia.

Discussion opened by Drs. W. C. Lester and W. W. Phillips.

(2) "Instrumental correction of Prostatic Obstruction" by Dr. T. D. Moore, Memphis, Tenn.

Discussion opened by Drs. R. G. Grant and George Brown.

(3) "Diagnosis and Treatment of Seasonal Hay Fever" by Dr. A. H. Little, Oxford.

Discussion opened by Drs. Ira B. Seale and S. E. Eason.

(4) "Anesthesia in Surgery of the Thyroid" by Dr. L. S. Brown, Water Valley.

Discussion opened by Dr. J. C. Culley and C. M. Speck.

(5) "Traumatic Surgery of the Extremities" A Motion Picture, Courtesy of Davis & Geck, Inc., Brooklyn, N. Y.

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Held at Amory, Tuesday, June 21, 1932

PROGRAM

1. Meeting called to order, Dr. W. C. Spencer.
2. Invocation, Rev. J. F. Measell.
3. "Diorrhea of Infants and Children," Dr. J. F. Eckford.

   Discussion opened by Drs. Hood and Reed.
4. "Abscess of the Liver," Dr. R. H. Christian.

   Discussion opened by Drs. L. C. Feemster, Jr. and R. P. Donaldson.
5. "The Value of the Sex Harmone Test in Gynecology," Dr. W. T. Black, Memphis, Tenn.
6. "Radium Therapy with Report of a few Cases," Dr. W. H. Anderson.

   Discussion opened by Drs. J. R. Williams and M. Q. Ewing.
7. Business Session.

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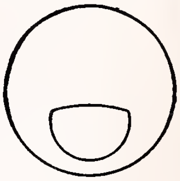

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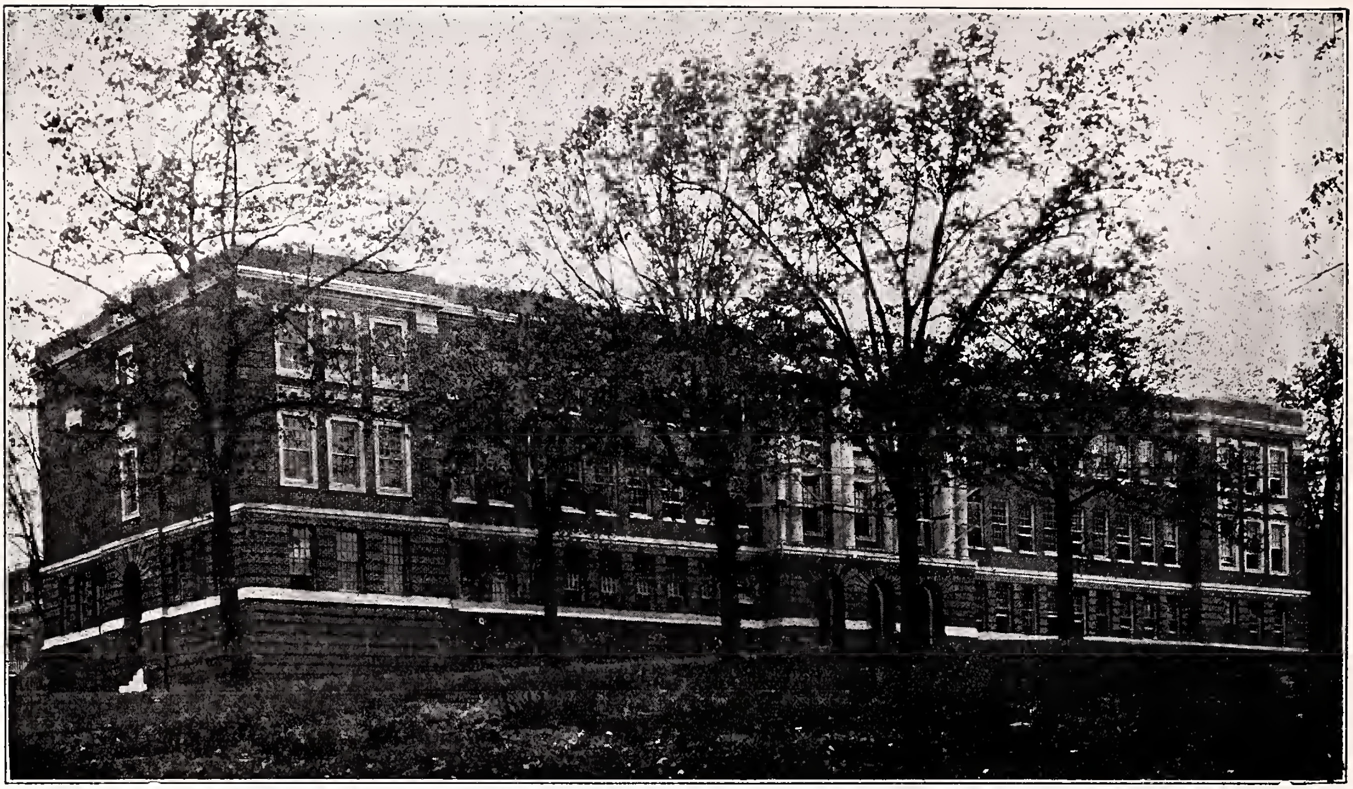

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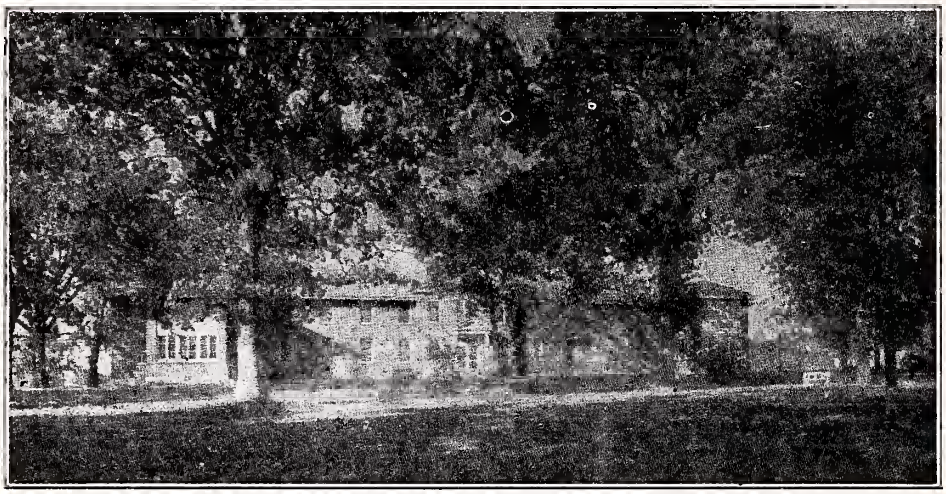

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The G. S. Bryan Issue

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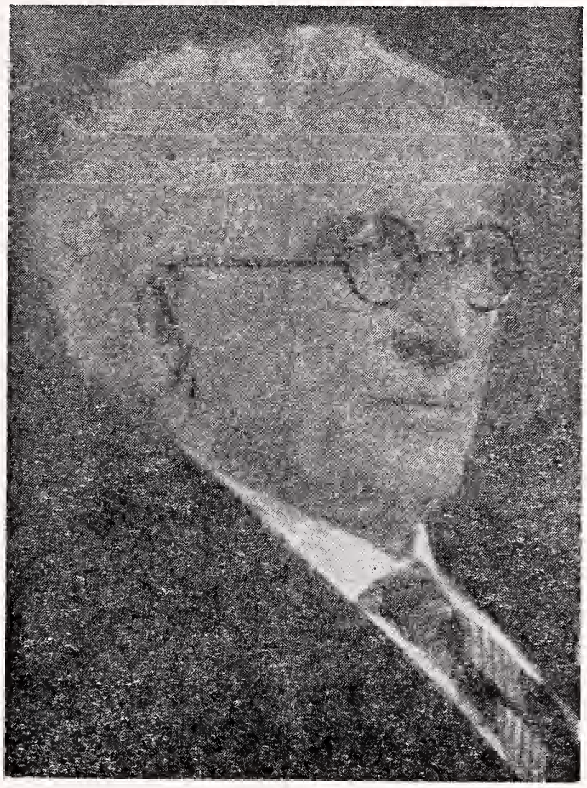

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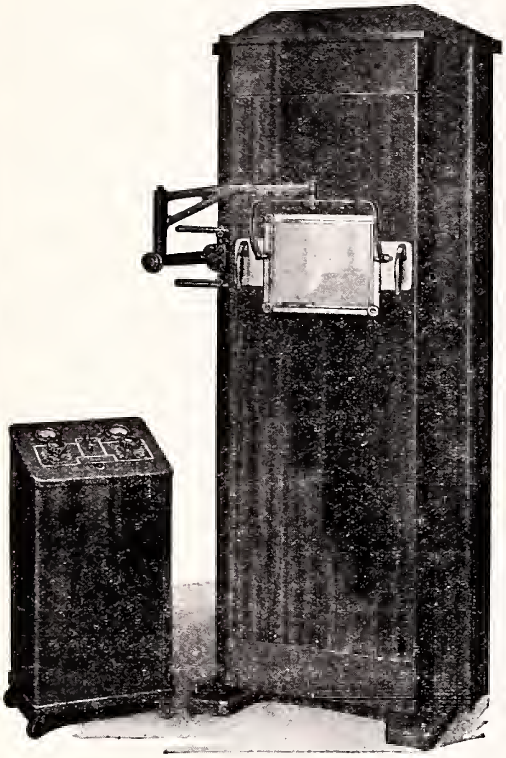

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OFFICIAL ORGAN OF THE NORTHEAST MISSISSIPPI 13-COUNTY MEDICAL SOCIETY
—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

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The passing of Dr. W. D. Beachan of Hattiesburg took from the profession one of the very fine medical spirits of Mississippi. After many years as a successful practitioner he took up public health work. He was one of the leading public health men of the state. He loved the practice of medicine. He loved public health work. He delighted in helping to keep people well. He possessed a big sympathetic human heart. To help others did him good like a medicine. He loved justice and he was a loyal friend. The medical fraternity in Mississippi will feel his medical spirit for years to come. His son, W. D. Jr., is our Ole Miss reporter for The Mississippi Doctor. Like his father he does things exceedingly well, and he has the marks of a manly man. We shall miss the friendship of Dr. Beacham. The Mississippi Doctor extends its sincere smypathy to the bereaved family.

We appreciate a reprint on The Acute Abdomen by Dr. E. M. Holder of Memphis. It is a classical piece of surgical literature. In addition to being full of human wit and philosophy, he writes with a facile and a gifted pen. He is widely read in medical literature and he writes out of very unusual personal surgical experience. The pages of The Mississippi Doctor are ever open to the gifted and experienced pen of the distinguished Dr. Holder.

Dr. Felix J. Underwood recently spent some time in the east in the interest of public health for Mississippi health funds have been cut until it is very hard to keep up the efficiency of the machinery. Dr. Underwood's resourcefulness is of great value at this time in enabling us to carry on in public health. He is recognized now throughout the United States as one of the leading public health executives.

It seems that the Baptist and Methodists Hospitals of Memphis do not allow men outside of Shelby county to operate within their walls. The surgeons of Memphis cover the entire territory round about and they are treated nice and they are welcomed, and they operate. The time has come when the city limits should not be any bar to medical or surgical knowledge. It did not count with the Mayos who have established the greatest medical center in the world. Mississippi is very largely responsible for these hospitals and the policy they are pursuing is not in keeping with the code of ethics of these great denominations, neither does it show the right spirit in the present progressive age of medicine and surgery. It is not a policy that justice will continue to tolerate.

It is one thing to talk medical ethics, and rear back with a lordosis, and it is quite another to practice it to the benefit of the patient for which it is intended.

Read Dr. Acker's brilliant tribute to Dr. G. S. Bryan.

Dr. A. H. Little of Oxford gives us a timely paper at this time.

Never have any disease to day that you can put off until tomorrow.

It is as difficult to meet brilliant success without losing one's head as it is to meet failure or misfortune.—E. Lee Vincent.

The work we love to do physics pain—Shakespeare. So if you love the practice of medicine it is pleasure for you and comfort for your patient.

You will read with much profit the paper of Dr. R. A. Hennessey of Memphis read before the North East Mississippi Medical Society at Booneville in March. The type of operation he is discussing bids fair to render a great service. So many men have obstructing prostates. They are usually bad surgical risks. If this simplified operation will give relief it will indeed be one of the big things in surgical progress.

We are delighted to have a renewal of advertising by The All States Life Insurance Company. The Mississippi Medical Association carries a blanket policy with this company. This is a splendid form of protective insurance. To hold a policy of this type means that you are practicing brotherly co-operation in the profession. You send your renewal to Dr. T. M. Dye, our most efficient state secretary.

Dr. C. M. Speck is a member of the hospital standardization board to check over the community hospitals of the state to see if they are equipped to take care of charity patients for the state with safety. He was appointed by Dr. J. M. Acker. Dr. Speck is putting in lots of time for little pay on this job. North Miss. should feel grateful to him for this service. He is doing his part of this job in a broadminded and a sensible manner. We congratulate him and we appreciate his services.

It was a great delight to have Dr. W. T. Black of Memphis to read a paper before our society. You will read his paper with much interest. It is on a subject that is new. In fact the test has not yet been simplified yet to where it is practical to be used in the small town and rural community. The Harmone test for Pregnancy is a great addition to medical science. It is hard to be positive about a normal pregnancy some times. It is of the greatest importance to know about a tubal pregnancy many times. To be able to tell positively whether a woman is pregnant or not by a urine test is of the greatest importance in many ways.

Dr. J. A. Rayburn and son have located in Pontotoc and are actively in the practice. Dr. Rayburn was Superintendent of the State Charity Hospital of Natchez for four years. From the information we have, he made a splendid superintendent. But the political spoils system came rolling along and carted him out. We welcome the Doctors Rayburn back to our society. Dr. J. A. Rayburn has been an active promoter of the community hospital idea for many years. We feel quite sure he will establish one in the good town in which he is located.

Dr. Nathan B. Lewis of Vicksburg gives us a good paper on anesthesia During Labor. The paper generally speaking sounds very SOUND. He refers to Morton as giving us ether anesthesia when it was our own Crawford W. Long of Georgia. What. Dr. Lewis says about anesthesias in labor we believe is in the main very true with one exception. Gas anesthesia given with the little portable McKission is safe and sound and inexpensive and in reality taken one case with another is the one of choice. We thank Dr. Lewis for his paper for The Mississippi Doctor.

Our June meeting at Amory was a big success. We were happy to dedicate it as a "Bryan Meeting." Amory is a delightful little city. It is nice and clean and beautiful. It has a citizenship of culture and refinement and education, with clever hearts and a cordial hand. Amory has a citizenship that is forward looking, one that is interested and informed on both local and national problems. It is a city that seems to be weathering the hard times better than the average. It has a spirit of optimism. It has an able and a clever medical profession. The Gilmore Hospital is a nice institution located within its limits. It has an able surgeon as its superintendent in the person of M. Q. Ewing. The medical atmosphere seemed heavily charged with the "Bryan Spirit." Amory was the first town in Mississippi to yield natural gas of the commercial variety. It will likely yet prove to have the most substantial and the most lasting although our capital city has a world record now. The medical profession of Amory may have gas stimulation to a certain degree, but not more than enough to stimulate to action the fundamental principles of medicine and surgery in which the profession is well grounded.

Thusly in this atmosphere a splendid scientific program was rendered. Dr. W. T. Black of Memphis was the visiting essayist. You will read his paper with much profit and with keen interest. He discussed a new test that means much in the progress of our profession. Dr. Black is one of the outstanding gynecologists of the Mid-Southern States, and we were muchly delighted to have him appear before our society. Drs. J. F. Eckford and R. H. Christian read splendid papers. They proved their studiousness and indicated more than average practical ability by these splendid essays. Dr. Speck of New Albany was an appreciated guest. He discussed the working plans of the charity funds for the community hospitals throughout the state. Dr. Speck has plenty of common sense and practical ability. We appreciated his services in this capacity.

The banquet followed the scientific session in the basement of the spacious Baptist Church of which our College comrade Dr. John F. Measels has been pastor for a number of years. He has this church charged with a good broad-minded, practical, and livable religious atmosphere. The banquet was bounteous and its tasty exquisiteness indicated the hand of Southern culinary artist which has not yet been surpassed in the feeding of civilized man. Dr. I. P. Burdine was toastmaster. He did it with the ease, and the grace and the appropriateness of the professional which proved his natural ability in this art. The climax of the banquet came when our most efficient secretary, our honored state president, our progressive citizen, Dr. Jimmie Acker paid a glowing and a deserved tribute to the beloved and the esteemed Dr. G. S. Bryan of Amory and moved that this be dedicated as a Bryan meeting. With one accord it was so declared. It was a generous tribute, deservedly contributed. Dr. Bryan has indeed and in truth proved a noble spirit in the profession. He loves the work in the profession. He has had high ideals and he has stood by them like a Spartan soldier. Indeed he has the profession mind, the medical soul, and the missionary heart. It gave the society much satisfaction from the depth of the heart to pay this tribute to Dr. Bryan. Since we had a Bryan Meeting in June, we take the liberty to declare the July issue of The Mississippi Doctor the Bryan Issue.

The Memphis Medical Journal comes along with an issue on Medical Economics, medical fees and hospital charges et al. Drs. Hedden, Campbell and Warr are prominent among the contributors. You would do well to read the June issue of this splendid journal. They bring out some good points on a timely subject. We have been hammering constantly on this subject for more than ten years. The economical stress of the times has brought many to think of the seriousness of the problem at this time, especially as it relates to the class forgotten by the medical profession, the rank and file, the middle class. What to charge and how to collect it is the big problem. The middle class must be served at less cost and at the same time the medical profession, the middle class of the profession, must have more money. How to do the job for less money and more profit is the question. It is the challenge. The decentralization of the medical profession, the development of the small medical centers in the counties, the community hospital and the well equipped clinic, the practice of preventive medicine and preventive surgery out in the midst of the people will do this thing that at first sight has looked impossible. Nine tenths of the medical service to the rank and file should be rendered by nine tenths of the profession. In other words not more than one patient out of ten need to see a specialist and one out of ten of the medical profession is enough to do this work. An expensive hospital and expensive equipment do not take the place of a well trained physician or a well trained surgeon. It is time to learn what the essentials are in a hospital. It is time to clip off a few yards of the red tape. The development of the community hospital and the country clinic are of the greatest importance in our medical economics.

A Tribute to Dr. Bryan

BY DR. J. M. Acker
Aberdeen, Miss.

On one occasion I was greatly impressed when I heard one of our truly great men and doctors expressing, in his appreciation of an honor recently conferred upon him, use these words, "There is no man living in the state whose attainments, ability or brilliancy can match this honor." He had reference to being president of the Mississippi State Medical Association, and those were the exact words in his presidential address. A slight change in this quotation would very nicely express the predicament I am in tonight when I try to really express my thoughts and feelings in the matter I am about to discuss. I am well aware of my inability to do justice to my subject, and, in the words of my honored friend, I know that I have not the attainments, ability or brilliancy to express myself as I should like. For that reason I have chosen to write what I have to say, rather than trust myself to speak what I have in mind and what my society would have me say.

May I disgress a minute to say that there are probably two other gentlemen in this assembly who know what I am trying to do. They know the object of my getting up, but they have not the remotest idea of what I am going to say. I wonder what will be the thoughts of one member of our group. Regardless of my failure to adequately express the true feelings of the society, I know that when I have said what I have to say, it will be the unanimous desire of the Northeast Miss 13 County Medical Society that this day and this meeting be dedicated to one of our most active and beloved members, a gentleman whose name I shall call later and who for many years has meant as much, if not more, to our society than any man in it.

In 1903 this gentleman was secretary of his county medical society and that year attended the State Medical Association as a delegate.

This, of course, was his first meeting. Since that time, twenty-nine years ago, he has missed only two of the state meetings, due to sickness. I know of only once that he has missed his local medical society meeting and that was because of a severe accident.

No person can know this gentleman doctor and help realizing that through his many activities the medical profession has profited much. His local society could not have functioned without him. A survey of his life's history is most interesting and typical of the life of many great men. He was born in 1863 at Aberdeen, the youngest of three children, his mother dying when he was less than a year old. For several years he lived with an uncle and aunt and experienced, as did many others, the poverty and hardships of Reconstruction Days. His father married again and he, his brother and sister returned to his father's home. His first school was a private one, located on Meridian Street, in Aberdeen, and taught by a Mrs. Bullock. To his father, however, is due the credit for most of his early education. He must have been an excellent teacher, as later results have proved. Later he entered the University of Mississippi but was unable to complete his literary course due to financial troubles. He taught school in the country near Aberdeen and thus secured finances enough to enter what is now known as the Medical Department of the University of Tennessee. He was graduated as valedictorian of his class in 1888. Under Dr. W. B. Rogers he served as interne in a Memphis hospital. Next came a practise of about fifteen months at Jasper, Ala. Later he moved to Amory and in 1890 returned to Jasper to receive the profits of his practise there, a bride, in the person of Miss Mollie Little. There were six children from this union. Only two living daughters remain. Both of these young ladies are interested and have been engaged in public health work, an interest undoubtedly inherited from their illustrious father.

Now, my friends, I have made clear who the subject of my essay is and who our society loves and honors. After hearing these feeble expressions of appreciation of a really great man, I move that in honor of Dr. Giles Sanford Bryan we dedicate this meeting as a token of our affection and esteem.

GATES AJAR

Gone from this life
Is Rush Along Bill,
He would pass other
Cars on a hill.

—Ed Scanlan in the Buffalo Evening News

The Value of the Harmone Test (Aschheim-Zondek Test Modified) for Pregnancy in Gynecology

BY Wm. T. BLACK, M.D., F.A.C.S.,
Associate Professor of Gynecology,
University of Tennessee,
Memphis, Tenn.

There has not been presented a more valuable laboratory test to the Gynecologist, the Obstetrician, or the Internest than the sex harmone test for pregnancy. A vast amount of literature from all parts of the world has appeared since Aschheim-Zondek suggested the use of the harmone from the anterior-hypophysis to diagnose pregnancy, in 1928. The Aschheim-Zondek test utilizes young mice—injecting subcutaneously the urine of pregnant women, which contains a large amount of the harmone from the anterior pituitary gland. This harmone is also found abundantly in the blood and saliva during pregnancy.

Mathieu and McKenzie make use of female rats, while Brouha suggested the use of male rats. Davis and Ferrill use the female rat about 25 or 30 days of age. Immature male rats may also be used, which will produce changes in the seminal vesicles, prostate and vas deferens. Davis and Ferrill inject the urine into the peritoneal cavity. Schneider and Siddall use the blood serum of pregnant women in making the test. Many observers, including Allen and Dorsey, Evans and Long, Weisner, Frank, Smith and Engle, Corner, Friedman and others have contributed valuable information upon the hypophyseal harmone.

Friedman's modification of the Aschheim-Zondek test is the most commonly used, and the one which has been used by those making the test for the writer. Friedman uses the isolated, female virgin rabbit in the place of mice and rats, as advocated by Aschheim-Zondek, and others. He injects the urine of pregnant women into the veins of the rabbit. Schoeneck and other workers claim that often a positive reaction is obtained in 24 hours, but 48 hours is more certain.

The test is nearly 100 per cent perfect, when properly performed, in making a diagnosis of pregnancy. In 4,802 tests thirty observers report only 1.07 per cent failures. In 652 cases, not supposed to be pregnant, there was a positive report of one per cent. A positive test can usually be obtained in from two to three weeks after pregnancy occurs. Therefore, a diagnosis can be established long before one can be made from a physical examination. In differentiating pregancy from other conditions it is of paramount importance. Just as long as there is alive attached chorionic tissue, the test is positive. This fact enables one to establish a cause for uterine bleeding in abortion cases, also after a miscarriage and labor one can positively assume the presence of the products of conception, if the test is positive. If you have a dead fetus, you will get a negative report in a few days, which will aid you in determining the death of the fetus.

In patients with indefinite tumors, when difficult to differentiate, the Aschheim-Zondek test is of supreme importance. The utilization of the test in diagnosing tubal pregnancy and in differentiating ruptured tubal pregancy of a few days duration from other pelvic masses is apparent.

In a hydatidiform mole and in chorio-epithelioma the test is of utmost importance. The test will assure you of the complete removal of all products of conception after operative cases is negative.

Much information has been obtained in the study of the physiology of the anterior hypophysis in the past four or five years. Its value here in contributing its harmone to the blood stream and urine, saliva, etc. in pregnant women making possible the test for pregnancy is only a meager function it performs. The anterior pituitary body is pinkish gray in color and soft in consistency and is connected with the posterior pituitary by the pars intermedia. It is located in the sella tursica and communicates with the brain through the infundibulum. It is composed mostly of eosinophilic, basophilic and chromohome cells. It has five harmones, or at least, harmones which act in five different ways. It has long been known that during pregnancy the chromophobe cells change and take on the characteristics of new cells (pregnancy cells). Knowledge of the hypophyseal harmones helping to regulate metabolism and the somatic cells causing growth, especially of the skeleton has also been known. It is a true sex harmone, that is, it stimulates the ovarian harmones to cause growth of the generative organs. It produces estrus in spayed animals.

Prolon A. (Rho 1 Weisner) acts upon oestrin of the follicular system of the ovary and prolon B. (Rho 11) acts upon the progestin of the corpus luteum. It therefore helps to regulate menstruation, as well as the secondary exual characteristics. The fact that folliculin and progestin are in some ways antagonistic to each other rather convinces one that the harmone from the anterior lobe of the pituitary are separate harmones. The fifth hypophyseal harmone acts upon the breasts.

Due to the fact that you have a hypertrophy of the basophilic cells after castration it is rather convincing proof that the harmone of these cells is the chief regulator of the ovaries. It is thought by some that the eosinophilic cells have more to do with the metabolism. As before stated it has never been conclusively proven whether there is but one harmone which regulates the follicular and corpus luteum systems or whether the same harmone acts upon these bodies and as they have different effects, the stimulation of each may activate the physiology of both systems. The harmone from the follicular system produces an increase in flow and estrus and, according to Novak and Montgomery, uterine contractions; while the harmone from the corpus lutem prepares the endometrium for the proper nidation of the fertilized ovum and lessens the amount of flow, and is said to antagonize the follicular system in other ways. From the above enumerated facts the anterior pituitary lobe is properly classed as the regulator of the ovaries.

Below are reported a few cases demonstrating the test.

Case 1. Mrs. B. was brought to the Baptist Hospital on 4-3-32, with a history of uterine bleeding for 7 weeks. Although she had been sterile for several years of her married life, her physician thought she had an abortion. The Aschheim-Zondek test was advised in this case, but due to expense and time, the test was not made, but a diagnostic curetage was performed. The laboratory reported that there was nothing in the scrapings to account for the bleeding. This patient had a retroverted, fixed uterus and a chronic pelvic infection. No doubt the stimulation from this chronic inflammation of the ovaries caused the uterine bleeding. If the test had been performed in this case, as advised, the diagnostic curetage for retained secundines would not have been performed, as the test would have been negative.

Case 2. Mrs. B. 31 years of age married, entered Baptist Hospital on 2-26-32 for uterine bleeding. Stated that on January 17th she passed a fetus about three inches long. She had continued to bleed from that time until she entered the hospital. Previous menstrual history had been normal, as well as the family history. Wasserman was negative. Patient was running a slight rise in temperature and an increase in leukocytes. Sedimentation time was slightly increased. The Aschheim-Zondek test was negative, on 3-1-32 also 3-10-32. On 3-1-32 a D. & C. by the house physician was performed obtaining some small fragments, which the pathologist reported as glandular hyperplasia with a round cell infiltration. In two or three days the patient commenced to bleed again and on the 3-14 another D. & C. was performed by the writer. Soft hemorrhagic fragments were obtained and the pathologist reported that there was present a sub-mucous polyp. This patient evidently passed all of the products of conception on 1-17. This was followed by a low grade infection of the endometrium and accompanying this was a uterine polyp, which accounted for the uterine bleeding. In this case the pathologist was able to show that the tests were correct, although she had recently passed a fetus.

Case 3. Mrs. M. Had an abortion in December, 1931. Entered the hospital 1-8-32 for uterine bleeding. Very anemic. After blood transfusions and building the patient up, a D. & C. was performed on 1-18. Pathologist's report showed degenerated products of conception. She continued to have some uterine bleeding for a few days, and on 1-22 four days after the D. & C. was done the Aschheim-Zondek test was reported negative. Due to the negative test she was left alone and made an uninterupted recovery in a few days.

Case 4. Mrs. R. 27 years of age, entered hospital on 2-5-32. Had been sterile for four years of married life. Suffered a great deal with dysmennorrhea, leukorrhea and menorrhagia with clots for the past month. Her abdomen had enlarged, as well as her breasts, and had an unusually heaving feeling in the pelvis. She had had quite an increase in flow and large clots were passed for ten days. An abortion was suspicioned. Aschheim-Zondek test was negative. Patient was operated upon. She had a uterine adeno-myoma. We did not feel safe, in the presence of this history, to operate until the negative test was reported.

Case 5. Mrs. M. 52 years of age, mother of 13 children, entered hospital in March with the following history. For the past year frequently missing her periods for two or three months at a time. Had missed two months upon entering the hospital. Pelvic examination revealed a complete laceration of perineum, a cystic degeneration of the cervix and an enlarged uterus about the size of a three month's pregnancy. Felt much like a myomatous uterus. Ascheim-Zondek test was reported positive. She was delivered of a hudatidiform mole. No one would have suspicioned pregnancy in this case due to her age. There were no other signs of pregnancy present, except enlargement of the uterus. In a case of this kind the test will prove of inestimable value.

Case 6. Mrs. A. Came to me for an operation. She had never been pregnant, but was overdue for about three weeks. Due to amenorrhea, the Aschheim-Zondek test was made and was negative. The operation was then performed for retroversion and chronic pelvic inflamation. The negative test relieves one's responsibility much in such cases.

Case 7. Mrs. G. Presented herself for an operation for a laceration of the cervix, third degree retroversion, and chronic pelvic infection. Mother of one child few years previously. Missed her period for six weeks. She would often be delayed for several days with her menstruation. For fear of pregnancy as Aschheim-Zondek test was made and the report was negative. A repair and hysterectomy were performed. The report was correct and assisted in making a differential diagnosis.

Case 8. Miss G. Consulted me for dysmenorrhea and amenorrhea. She stated that she was often delayed from one week to one month with her menstruation. She had missed her period two weeks, but did not suspicion pregnancy, except that she felt differently in her brests and had a heaviness in her pelvis, and frequent urination. She had not had these symptoms before. The Aschheim-Zondek test was made and was reported positive. She later had an abortion performed. This case was confusing without the aid of this test.

Case 9. Mrs. P. 20 years of age. Entered Baptist Hospital 1-21-32. One child, 3 years of age. Nine months before entering the hospital she passed a hydatidform mole, which was followed by uterine bleeding. During the nine months before entering the hospital she had had five curetments for uterine bleeding. Upon entrance her blood count was 2,780,000 red cells, 13,900 leukocytes, 15 S. L., 85 polys, hemoglobin 50 per cent, Sedimentation Time 15 minutes. Aschheim-Zondek test was made and reported positive. A D. & C. was performed on 2-4 after tranfusions and other forms of treatment had been given. Pathologist's report, (frozen section,) was the presence of a chorioepithelioma. On 2-15 all pelvic organs were removed. Three weeks later the test was positive. One month later it was mildly positively. This case will be followed up with tests and X-ray examinations for one year.

Case 10. Ida J. Entered Memphis General Hospital on 9-10-31. Colored female. One child, age 4 years. Menstrual history normal. Gave history of not missing her period. The date menstruation was due she lifted a tub and had a sudden right sided abdominal pain. Commenced to bleed, became very weak and had to go to bed. Continued to bleed and passed clots for two weeks. Ran a temperature ranging from 100.5 to 103 degrees. Blood count showed hemoglobin 70 per cent, red cells 3,500,000, neutrophiles 80, whites 9,500, L. 20. Wasserman 4 plus. Kahn 3 plus and Kline 1 plus. Sedimentation time 9-11-32 18 min., 9-13 8 min., 9-20 10 min. Her urine showed granular casts and a few pus cells. Pulse was fast and weak. Patient was extremely weak and had the appearance of a septic condition. She was treated for a few days believing that she had a pelvic inflammatory mass. There was no definite history of a ruptured tubal pregnancy. There was none of the early symptoms of pregnancy present. On 9-17 the Aschheim-Zondek test was reported positive. On 9-21 operation revealed a ruptured tubal pregnancy. This case demonstrates that the Aschheim-Zondek test proves of inestimable value in cases of ruptured tubal preganacy that have existed for a few days (if secundines are still attached).

Case 11. E. S. 20 years of age, white. During August, 1931, was admitted to General Hospital for operation for a third degree retroversion of the uterus. Patient had missed period of one week. Aschheim-Zondek test was reported positive. Patient was discharged. She returned in two weeks having a criminal abortion performed. Pregnancy not suspicioned from the physical signs or the history. Test prevented an operation in early pregnancy.

Case 12. E. S. age 16 years, white. Admitted to General Hospital July 31. A Juvenile Court Case. Was admitted for examination for suspected pregnancy. Aschheim-Zondek test was reported negative. In a few weeks she was again admitted and was still lacking the signs of pregnancy. Another negative Aschheim-Zondek test was reported. This case suggests the value of the test where legal questions might arise.

These cases and many more attest to the value of Friedman's modification of the Aschheim-Zondek test in Gynecology.

Transurethral Prostatic Surgery

BY RUSSELL A. HENNESSEY, M.D., F.A.C.S.
Memphis, Tenn.

Probably no surgical innovation affords greater promise for the relief of one of the most formidable difficulties of senescence than the more recent developments of transurethral prostatic surgery.

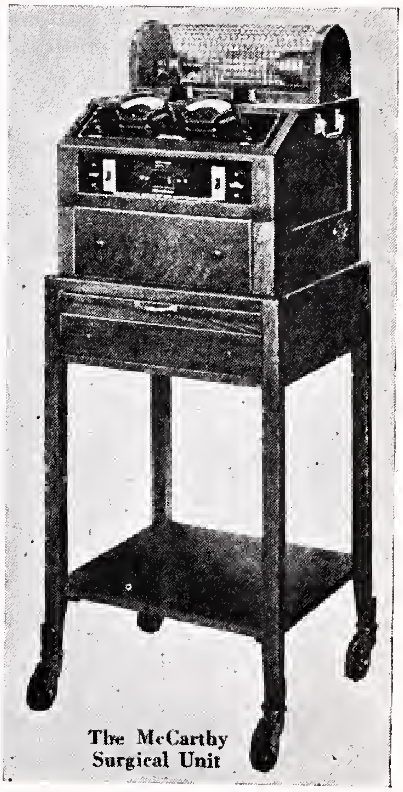
For many years a variety of ingenious appliances have been devised and used to accomplish a simple and safe relief from the obstructing lesions of the prostate through the urethra. While a few of these methods, notably those of Caulk, Collings, Braasch and Day, found some favor with the profession, their limitations were recognized. Except in the hands of a few, their value was limited to median lobe enlargements, bars or contractures at the vesical orifice. Through the pioneer efforts of Stern and Davis, and more recently with the added inventive genius of McCarthy, the radio loop resection under vision has been developed to a method of precision and exactness not surpassed by open prostatectomy. Hand in hand with these instrumental developments, electric cutting currents have been developed which will efficiently energize the cutting loop and make possible accurate tissue cutting and coagulation in a water medium.

DESCRIPTION OF INSTRUMENT AND ENERGIZING CURRENT

The McCarthy equipment which we have used in twenty-one cases, consists of a Bakelite sheath and obturator, observation telescope, wire loop electrode, and rack and pinion carriage. The cutting current is supplied by the McCarthy radio tube surgical unit, devised by Mr. Fred Wappler. Its development is looked upon by scientists as one of the most remarkable of modern electrical achievements. Its even current envelope makes possible smooth and even cutting of tissue, while its rapid oscillation facilitates excision of tissue with a minimum of desiccation. This should obviate in a large measure subsequent scar development or contraction at the bladder neck. Numerous sections removed by us have shown tissue destruction not in excess of one-fifth to one-half millimeter, or probably less than would be produced by the sharpest scalpel.

INDICATIONS AND LIMITATIONS

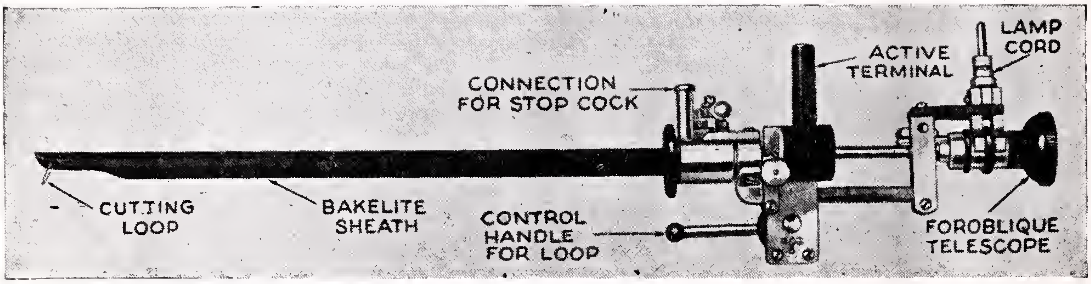
Transurethral prostatic surgery is as yet a surgical innovation. Its dimensions cannot at this time be properly appraised. In the veritable stampede that usually accompanies such surgical innovations, many errors may be committed to blemish the beauty of its performance.


The McCarthy Surgical Unit

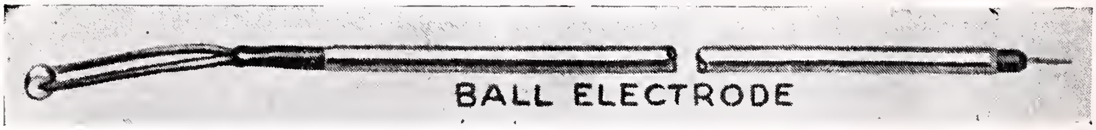
We believe that transurethral electro-excision is a monumental achievement in prostatic surgery, and that it will remain as a valuable urological procedure. We do not feel, however, that in its present state it will completely supplant prostatectomy, but that it may prove applicable in as high as eighty-five or ninety per cent of cases. Information concerning the breadth of its application will come only with careful study and analysis. Despite the fact that considerable resorption of tissue is known to follow drainage of the bladder or partial removal of the prostate, it does not, in the light of our present experience, seem applicable to the large intravesical growths or large soft adenomatous growth which exert their obstructive influence by encroachment upon the posterior urethra. We also feel that the further success of the procedure can only be assured in the hands of experienced instrumentation and those prepared to cope with the physical uncertainties of the prostatic.

TECHNIQUE

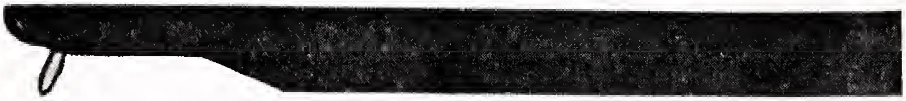
The McCarthy instrument is passed into the bladder, the obturator removed, the telescope and loop inserted and the posterior urethra and vesical orifice carefully inspected. The instrument is withdrawn to the veru montanum, which is the anterior boundary to which resection may be carried. With the use of the rack and pinion, the loop is passed over the obstructing portion of the gland and as the cutting treadle of the foot switch is pressed the loop is withdrawn through the tissue under the guidance of the eye, carrying with it a cast, comparing in size with a section of a lead pencil. This procedure is applied to the obstructing gland serially, until canalization is complete. As the resection proceeds, the bleeding points are promptly sealed by the application of the fulgurating current, furnished by the second treadle of the foot switch and generated through the loop electrode. At the completion of the resection, a catheter is placed in the bladder, where it is permitted to remain for from two to four days.



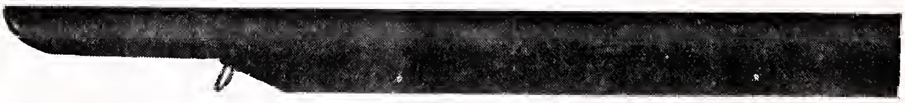
Note position of loop. Size of sheath 28 Fr. Length of cut 1”.



CUTTING LOOP



Loop at extreme distal position. Although it projects from the side of the sheath it is guided into the sheath on its excursion.

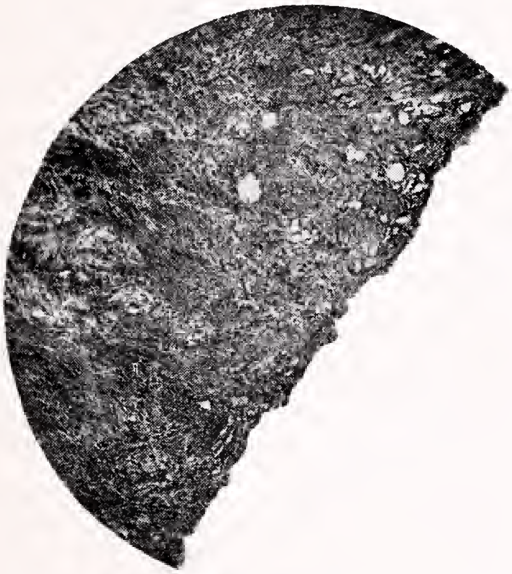


Loop gradually lifts out of tissue near the end of excursion. In extreme proximal position the entire loop has entered the sheath.

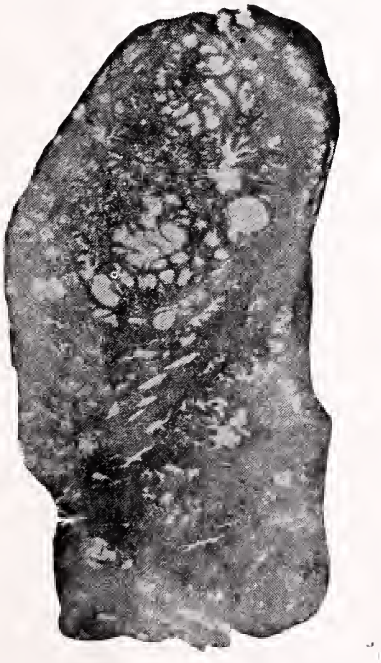
Preoperative care, which has been largely responsible for the lowered mortality that has been attained in prostatectomy, is fully as necessary to the patient upon whom transurethral resection is contemplated. This procedure involves the following general consideration: Relief from the distressing necessity of frequent difficult or painful attempts at urination; relief from urinary sepsis; improvement of renal and hepatic function; safeguarding of the cardiovascular system; improvement of the water balance and replenishment of the body nutrition. This responsibility often proves in cases of marked prostatism to be a sizable task, which may require a week or weeks of preoperative care. Uninary drainage may be accomplished by inlying catheter or suprapubic drainage, as the necessities of the case may require.

What, then, one may properly ask, are the advantages of trans-urethral resection, particularly when the avenue of approach has been established by a cystostomy opening. This, and other pertinent questions may be answered abstractly as follows:

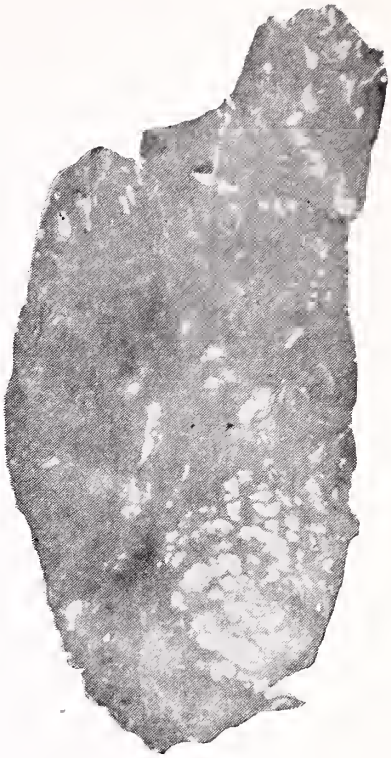
1. The resection method permits a more accurately controlled and exact removal of the obstructing prostate than open prostatectomy.



Photomicrograph showing small amount of tissue destruction at cut margin.

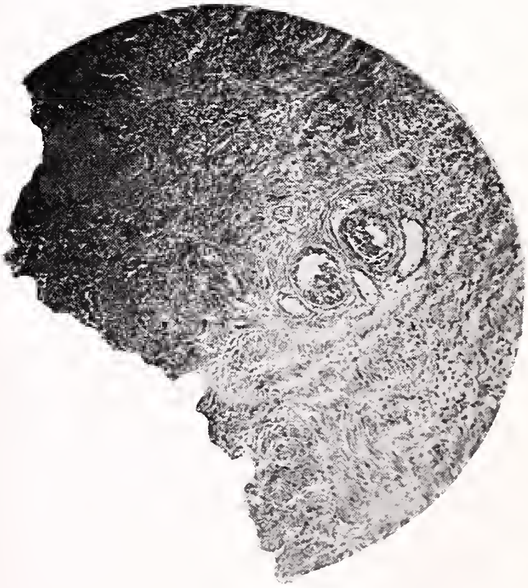


Photograph of section of prostate tissue excised by McCarthy resectoscope.



Photograph of section of prostate tissue excised by McCarthy resectoscope.

2. Risk to the patient is reduced to a minimum. Postoperative shock is practically unknown. Postoperative morbidity is reduced to a remarkably low degree. The large area for absorption remaining after prostatectomy is obviated by the sealing of the tissues following electro-excision. It has not been uncommon in



Photomicrograph showing small amount of tissue destruction at cut margin.

our cases for the body temperature to remain at or rise only slightly about normal during the postoperative course. In only four of twenty-one cases was it necessar yto administer a hypodermic in the postoperative course.

3. If sufficient care is exercised at the time of resection, the hazard in postoperative hemorrhage is negligible. Postoperative pyelonephritis may in a large measure be obviated by the administration of intravenous uritone, postoperatively.

4. It is not an inconsiderable item that the postoperative course need rarely be over four to seven days. The large toll of pulmonary and cardio-vascular complications occasioned by prolonged indigence in the aged is well known. Hospital and other expenses incident to a prolonged hospital stay is reduced to a minimum.

Anaesthesia During Labor*

BY NATHAN B. LEWIS, M.D.
Vicksburg, Miss.

Do we need an anaesthetic during labor?

"Unto woman He said, 'in pain thou shall bring forth children.'" (Genesis 3-16). This phase has passed into common speech and has become a byword throughout Christendom for half a hundred generations. I term this phrase not to mean actual labor, but the nine long months of gestation, the looking forward to the actual delivery, the knowledge of the danger which awaits the mother and her offspring, then after labor, the nursing stage, the thousands of dangers which might beset the offspring, the sleepless nights and the anxious days, A number of our older doctors term this sentence to mean the actual labor itself. Another passage in that famous book reads, "and to man He said, 'In the sweat of thy face shall thou eat bread.'" (Gen. 3-19). May I ask just how many men by the actual sweat of their brows eat bread?

So firmly established was this tradition of the pains of childbirth, that every pulpit gave an outcry against Dr. Morton's blessing to humanity, anaesthesia, in the nineteenth century. Now even in this twentieth century of ours there are physicians who are so cold blooded as to think that the suffering of childbirth is a natural phenomenon and that it does good to both mother and child. Thanks to the progress of science that we do have many physicians who have discarded this incredulous practice and who are now using an anaesthetic or who wish that they had some good anaesthetic to use. It is true that women soon forget the pain of labor. However, the portals of unknown medicine are open wide and we do not know just what goes on in the woman's body.

We do not know just what shock the nervous system received from such severe pain, but knowing as we do what happens in other conditions of severe pain we can draw but drastic conclusions.

To live in one sense of the word is to remember past experiences. How many have endured painful operations, and ever forgotten the date and details of such operations? How many here would think of an operation for appendicitis, caesarean section, or even a forceps delivery without the administration of an anaesthetic? The purpose of pain is to teach us to avoid the experience that produced the painful sensation. Well and good. Shall we term that this pain suffered by the woman in labor be that she must never have another child? It does not. It means that as physicians, we must do everything in our power to elleviate pain and suffering. Arriving at this conclusion the question now arises:

What anaesthetics are used:

(Numerous papers have been written on each of the following anaesthetics named: therefore, in a paper of this type, we shall give only a few notes on each.)

We must first agree with Swift that there are some women who are breeders. These I term the true precipitant, who has the baby easily without pain or trouble. They are few, but we have them.

Ether—our best surgical anaesthetic, our main standby in surgery, good. In labor too slow, and the dose to act too strong.

Choloroform—An excellent obstetrical anaesthetic. Dangerous in the hands of the unexperienced. The old custom of one of the family giving this anaesthetic caused many disastrous results. This drug only lessens pain, it does not destroy memory. To obtain its full effect means to stop labor.

Morphine—Alone it only causes rest, has its place in the first state. Large doses stop labor and are responsible for a number of our blue babies and for most of the pre-partum pituitrin. Why stop labor and then give pituitrin to increase labor?

Nitrous Oxide—Very efficient obstetrical anaesthesia, is costly, requires a trained anaesthetists, only lessens pain does not abolish sensations. Used only in the second stage. In large doses deoxidizes the blood, has no after effects.

Rectal anaesthesia—If you have ever used any you may draw your own conclusions. It works in fifty per cent of the cases. Can be carried on fairly well in the home.

Medicinals (such as choloral, bromides, codeine etc.,) too light to do any good. May cause vomiting. When we combine with morphine we get the action of morphine.

Sodium amytal and like drugs—Good in eclampsia, a failure in obstetrics. Still in the experimental stage. All must be given at once to produce effects and the exact time to give same is not yet known.

Spinal Anaesthetics—Must wait until the patient has progressed too far. Not accurate, not dependable, somewhat dangerous unless a great deal of practice is had. Long been abandoned and brought back into practice. May prove excellent in the hands of some. Is, as yet, in the experimental stage. I omit somnoform, ethyl chloride, avertin, I have had no experience with them.

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*Read before the Issaquena-Sharkey-Warren Counties Medical Society Vicksburg, July 14, 1932.

Twilight Sleep (morphine-scopolamine)—This is to my judgment the best obstetrical anaesthetic, and in conclusion would like to discuss more fully this type of anaesthetia.

CONCLUSION

Twilight anaesthesia is in the main a hospital anaesthetic, but, can be used equally as well in the home. It requires only the care of the physician himself and no trained anaesthetist is required. Labor is not interrupted, no sensations or knowledge of the actual labor remains after the effects of the anaesthetic wears off. There are no contraindications except severe heart damage which would contraindicate any other anaesthetic if not labor itself. It is begun in the first stage, as soon as the physician is sure the patient is in actual labor. There is no single massive dosage, the dosage is given in small amounts and only when indicated, therefore, if there is any indication of a decrease in labor on administration of a dose, subsequent doses can be smaller, larger or further apart as labor progresses or retards. The reason for numerous blue babies in the past has been that the obstetrician did not have the knowledge of the administration of the drug. This knowledge requires only a few minutes' study and observation of a few cases. The old danger lay in the fact that too much morphine was given. I have, after numerous observations, worked out a routine that works in practically all cases. When the patient has her first hard pain or when the cervix is dilated enough to admit three fingers the first hypodermic injection of morphine, grains one-sixth, and hyoscine, grains one-thirtieth, are administered. It is very rare that a subsequent dose of morphine be given, and if given at all never more than one more dose and that dose never to exceed one-twelfth grain. As labor progresses and as consciousness persists, small doses of hyoscine alone are administered as the judgment of the obstetrician deems is necessary. This is accomplished with a little practice. The patient rests easily between pains, pains are not interrupted there are no after effects. Since only a small amount of morphine is used, spontaneous respiration follows in the child as it does in labors in which no anaesthetics are used. Statistics of its marvelous success at Frieburg are all that is necessary to confirm any statement of its use.

A LA KING

With television about to make its advent into our homes, all a doctor will have to do when we call him is pick up the receiver and tell us to stick out our tongues.

Diagnosis and Treatment of Seasonal Hay-Fever*

A. H. LITTLE, M.D.
Oxford, Miss.

*Read before the regular Quarterly Meeting of the North Mississippi Medical Society, Holly Springs, Mississippi, Wednesday, June 15, 1932.

Before attempting to describe the various methods used in the diagnosis of seasonal hay-fever I will give you a brief outline of some of the most common causes of hay-fever in this locality. Henry and Herring have made a very complete botanical survey of the territory surrounding Memphis and have reported many plants that most of us had not considered as important causative agents in hay-fever.

Spring hay-fever may be caused by pollen from trees, grasses, or weeds. Among the trees are the elm, hazel-nut, red maple, red cedar, oaks, pecan, sycamore, ash, black walnut, hickory, box elder, and cotton wood. Among the grasses are annual and Kentucky blue, hair-grass, fescue, orchard, and rye. Among the weeds are dock and sorrel.

Summer hay-fever may be caused from grasses or weeds. Among the grasses are bermuda, Johnson, timothy, red top, crab, and foxtail. Among the weeds are plantains, tall paspalum, lamb's quarter and pigweeds.

Fall hay-fever is usually caused from weeds, the most common offenders being the ragweeds, cocklebur, and marsh elder.

It is of utmost importance that one be informed on the plant life of his immediate vicinity before attempting to diagnose or treat hay-fever. The examination of atmospheric pollen plates will reveal valuable information as to the amount and variety of pollens in each locality. Thiberge and Hauser describe the technic of this examination very completely in their recent article on this subject.

The cause of most every case of seasonal hay-fever may be found after complete information has been obtained from the following sources: family history, past and present illness, physical examination which includes observation of the patient over a long period of time if necessary and specific tests. I will not burden you with the usual history outlines but will state only a few of the more important observations made from the history and physical examination.

In over fifty per cent of pollen hay-fever sufferers a postive allergic family history will be found in which the manifestations were hay-fever, asthma or hives.

In reference to the present illness it is important that the exact date of the onset of any or all symptoms and the exact duration of each symptom be determined. It is often possible to place the causative agents in the spring, summer or fall groups which will aid greatly in treating the patient.

The physical examination often reveals many conditions that may aggravate the symptoms of hay-fever, among them are a deviated nasal septum, nasal polypi, and chronic sinusitis. It is interesting to know that very few allergic patients suffer from hypertension.

Laboratory examinations in the form of microscopic studies of smears made from the nasal secretions are of some value. It has been found that a Wright's stain of the secretion from the nose of a hay-fever sufferer usually shows a relative increase in the eosinophiles while the secretion from an acute infectious condition will show an increase in neutrophiles.

The usual specific tests used for making a diagnosis of hay-fever are:

1. Nasal tests with dry pollen.
2. Ophthalmic tests with dry pollen.
3. Skin tests.

The nasal and ophthalmic tests are not so commonly used as the skin tests but are very valuable in many cases. According to Alexander only about fifty per cent of allergic patients will show positive skin tests. On the other hand according to Efron and Penfound and also from my own observation a few hay-fever patients have been found to give positive skin reactions to almost all the allergens with which they were tested. It therefore appears that in some cases additional methods of testing to the skin method are indicated. It was probably because of the variability of the reactions to the skin tests that the nasal and ophthalmic methods came into use. The nasal test as described by Efron and Penfound describes the technic in detail and the ophthalmic test as described by Peshkin gives the method of making that test equally well.

The skin test is used both by the cutaneous or scratch method as described by Walker and the intracutaneous method as advocated by Cooke, Duke and others. The cutaneous or scratch method should always be used before the intracutaneous method is used as severe local and constitutional reactions may follow the injections of pollen extract into the skin of those extremely sensitive. The scratch test is usually made by making a short superficial scratch on the skin and to this scratch is added a drop of tenth normal solution of sodium hydroxide and a small amount of dried pollen. Duke states that "the appearance of a hive, with pseudopods surrounded by an irregular area of erythema indicates a positive reaction." Many tests are made at the same time thus relieving the patient of numerous or prolonged visits to the office. Readings of the tests are made at intervals of a few hours and the varying degrees of reactions are recorded. Some hives may be very small while others may be very large depending upon the degree of sensitivity to the particular pollen. When there are mildly positive or negative reactions to the scratch test the intracutaneous method may be used. This is done by injecting very small amounts of varying strength pollen solutions in-

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tracutaneously. Similar reactions to those obtained in the scratch test are found in positives.

After completing the skin tests and having found the pollens to which the patient is sensitive and the degree of sensitivity as evidenced by the size of the hive our attention is now turned to the treatment. If it were possible to have the patient move to some locality where the offending plant did not grow the treatment would be relatively simple. That is not possible in every case for many reasons; the patient may not care to leave his or her relatives or friends, he may not be financially able to travel, or his business may require his attention during the hay-fever season. It must also be remembered that some grasses and weeds grow over almost the entire United States and that it might be necessary for the patient to leave his country to obtain complete relief.

It is possible to live at home and avoid contact with massive doses of pollen by exercising certain precautions of a more or less simple nature. Hay-fever sufferers should avoid automobile trips or hikes on country roads during the hay-fever season. They should have the windows of their bed rooms closed on the side from which the wind is blowing on windy days and even on non-windy days the windows should be closed after midnight. This prevents the room from becoming filled with pollen and relieves the acute symptoms greatly. The "Pollenair filter" which can be placed in a window in either the bed room or office reduces the among of pollen in the air to a remarkable degree and gives much relief. For temporary relief many rhinologists use local applications of ephedrine and cocaine in the nose followed by painting the turbinates with a two per cent solution of silver nitrate. They report very favorable results and in some cases find that the patient is almost completely relieved of symptoms for many days. Guyton reports much relief from the use of Estivin, zinc sulphate and tannic acid solutions dropped in the eyes. At this point I want to add that any operative procedures in the nose are inadvisable during the hay-fever season as asthmatic attacks may be precipitated and the healing process in the nose will be inhibited because of the congestion of the mucous membrane.

Even though every precaution may be taken to avoid contact with pollen it is almost impossible. Scheppegrell demonstrated that on windy days pollen was almost as abundant at five thousand feet above the earth as it was near the surface. It therefore becomes necessary to find other methods of treatment that will afford relief. This brings us to the specific treatment of hay-fever with pollen extracts. By this form of treatment the sufferer is desensitized by the subcutaneous administration of pollen solution of varying strengths, the solution being prepared from the pollens to which the patient is most sensitive. The treatment is begun by giving a very small dose of a high dilution and continued by gradually increasing the

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size of the dose and the strength of the solution until the tolerance dose is reached, then dropping back to the next lower dose and continuing this dose at weekly, bi-weekly or monthly intervals for a long period of time. The treatment may be preseasonal. seasonal, or perennial. In the preseasonal method the treatment is begun two or three months prior to the pollination period of the plants to which the patient is sensitive and carried on until the end of the season. In the seasonal method the treatment is begun at the beginning of the polination period of the plant and injections are given at very short intervals. one or two days or even shorter, and continued until the end of the season. In the perennial method as described by Aaron Brown the treatment may be started at any month of the year and after the tolerance dose is reached it is repeated at longer intervals as tolerance permits until intervals of three or four weeks are reached after which time the dose is repeated for a period of years at those intervals. In order to keep in closer contact with your patient it may be advisable to have him take his treatment at two week intervals especially during the hay-fever season. Vaughn recently reported results of treatment in fifty-seven cases of pollinosis during 1930 as follows:

Type of treatment	Excellent 90 to 100%	Good 75 to 90%	Satisfactory 75 to 100%	Fair 50 to 75%	Poor less than 50%
Coseasonal (15 cases)	40.0	20.0	60.0	26.7	13.3
Preasonal (21 cases)	38.1	33.3	71.4	14.3	14.3
Perennial (21 cases)	95.2	44.8	100.0	0	0

In my own experience I have obtained much better results from the perennial type of treatment and believe that many patients who have taken pollen treatment for a short time with little relief would obtain added relief from their symptoms and gain faith in the pollen treatment if it were continued over a period of years by the perennial method.

In closing I want to mention one other type of treatment that may be used in hay-fever and that is the acid therapy as described by Beckman. He reports very gratifying results by the use of mineral acids and diets that produce acid reactions. This form of treatment is based on the assumption that there is an upset in the acid-base balance in the body of allergic individuals resulting in a potential alkalosis.

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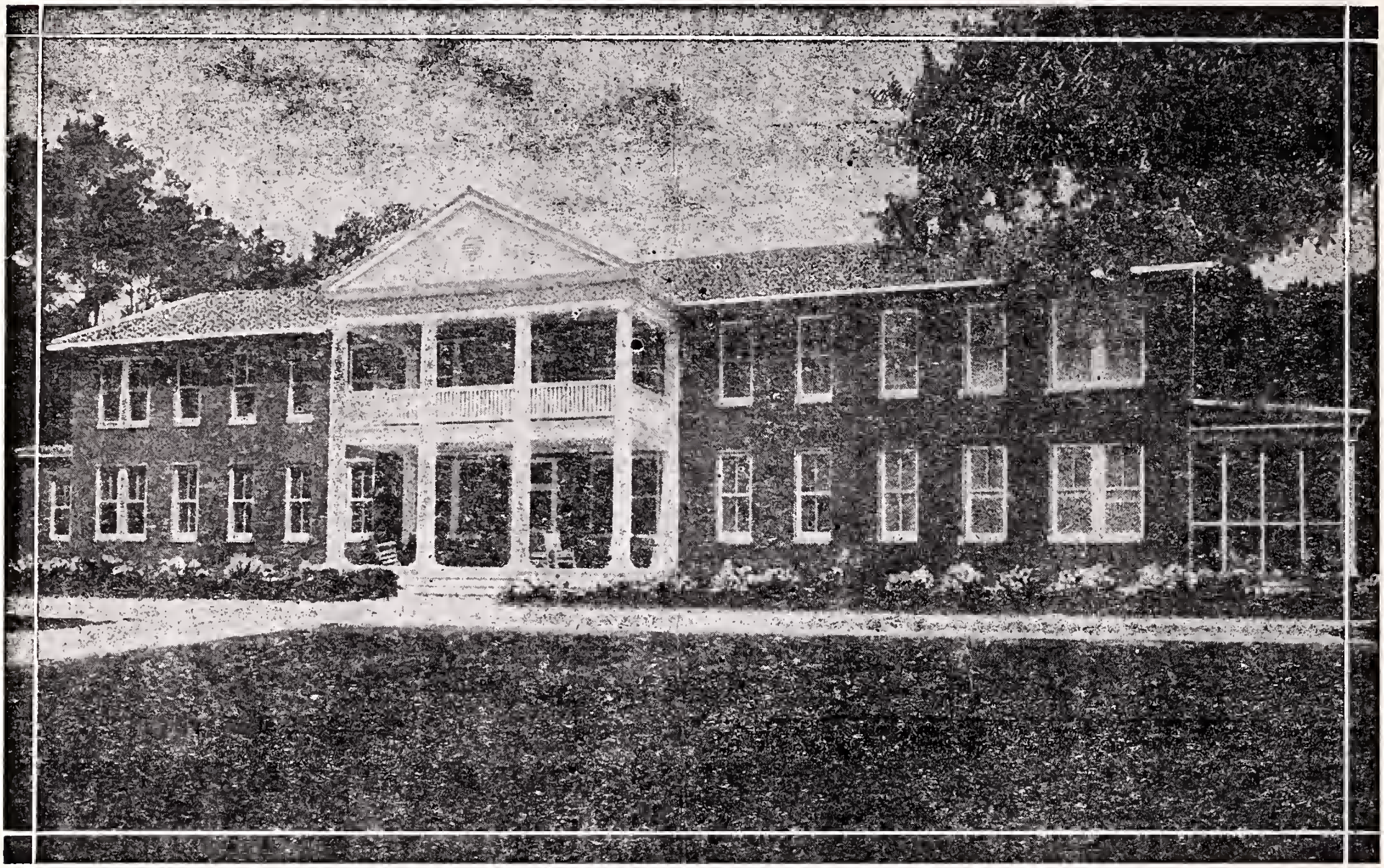

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They are slaves who will not choose
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Rather than in silence shrink
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They are slaves who dare not be
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—James Russell Lowell

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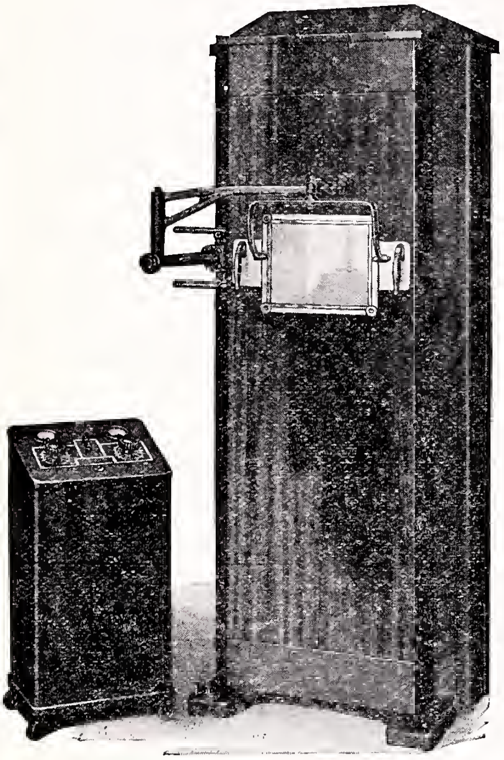

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—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

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Our next meeting goes to Aberdeen. Make ready now to go. You know the type of meeting this city puts on. Aberdeen is the nestor of Southern culture and refinement and cordiality.

Dr. L. L. McDougal who was on the staff at the state Insane Hospital for two years has returned to his home in Booneville to resume his general practice. Our society welcomes Dr. Mac. back to its fold. He takes an interest in the doings of the society and his help is most welcome.

Houston entertained the society in fine style as usual. A big crowd attended. Dr. E. M. Holder was the out of state guest. He is a great and learned surgeon who drinks deep from the fountain of human philosophy. Dr. Gardner of Columbia, President of the State Hospital association addressed the meeting. Dr. Gardner is not such a fluent speaker, but his address was most eloquent with facts and with sincerity. This was his opening address on the community hospital proposition. He is going to render the state a big service this year. Mark this. We will have more to say next month about his address. We hope to have it for publication. A fine banquet was staged at the Masonic hall. Dr. Philpot presided as toast master and did it exceedingly

Dr. W. M. Adams of the Anderson Clinic who spent six months in the Post Graduate of New York taking treatment and interning expects to return to the big city at an early date where he will probably be associated with one of the leading plastic surgeons of the Empire State.

Dr. Turner Googe who is the prominent health director at Meridian is taking a ten months course in Harvard. Dr. Googe has grown rapidly in public health work. He is one of the outstanding leaders in this most important field.

The fight for the rights of community hospitals has been long and hard. We are in sight of victory, but there is plenty to do yet. We must not stop. Since the hospitals themselves are becoming interested the outlook is much brighter. We need more hospital organization we believe. We want to suggest that the hospitals in the twenty counties served by The Mississippi Doctor organize at the Ole Miss meeting on October the fifth. We believe that we should have groups of hospitals like this over the state as an aid to the state wide hospital organization. Think about this. Our legislative program is not over yet. There is other work we can do. Let us have a meeting and talk it over. Don't forget. At Ole Miss, Wednesday, October 5th.

Don't fail to read the announcement of Dr. Beasley relative to the Fourth Annual Assembly of the Southeastern Surgical Congress which will be held in Atlanta, March 6, 7, and 8, 1933. It will be well worth your while to attend this meeting.

You will note resolutions by state Board of Health on Doctors Applewhite and Beachum.

Houston always has a large attendance at our quarterly meetings.

If the specialist in general surgery expects the country surgeon to refer him his complicated cases he must be big enough to discourage the ordinary appendix case traveling two hundred miles and paying five hundred dollars to have it removed. It is hard to beat the batting average of the country suregon on the ordinary every day emergency surgery. We must learn to think straight and act honestly with each other and the patient.

Last year Dr. J. C. Culley of Oxford, presi-
The Medical Profession in Mississippi regrets very much to give up Dr. C. C. Applewhite. He has been a great power in public health in our state for the last few years. He took to work just like a duck to water. He did it with system. He was an artist in using the last punch that it took to put a proposition over. He created a public health atmosphere. He had faith in its value to the public. He had courage and he carried clean living in both We regret to give him up, but we wish him much success in his new field.

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dent of the State Medical Association, formulated a definite plan of procedure with definite purposes in view. One was to aid the Medical Department of Ole Miss, first by using his influence with the medical council and next by selling the school to the medical profession of the state. Another important thing he undertook was the further development of the community hospital. And still another was to contact the profession of the state personally. He had a very productive administration. A medical meeting was held on the Ole Miss campus which was to do honor to Drs. Culley and Mull and to promote the medical school. It was a great success. This is to be repeated. On October the fifth another program is to be rendered. This should be well attended from the northern half of the state. We should feel a great pride in our medical department at Ole Miss. It will do you good to spend a day on the campus. You will be helped and you can help. Make your plans to be there. Remember the date, October 5, 1932. The day is Wednesday. It will be a profitable day. It will be a pleasant day. You can not afford to miss it. Let us all be there.

You will read with profit the splendid and well composed paper of Dr. George Kirby Sims of Laurel.

Dr. T. A. Moore of Byhalia has a very thorough paper on "Digestive and Infectious Diarrheas in Children." He covers the subjects well and full and he handles his subject matter in a logical and well arranged manner. You will read his paper with interest. We congratulate Dr. Moore on this paper.

We enjoyed a recent visit to a staff meetting at the Houston Hospital. They do the thing in fine style down there. They have the right idea. They had nice entertainment for the doctor's wives. There was a spendid attendance from the surrounding territory. The nurses were all present at the meeting. Some lay members of the town. Houston Hospital has its staff meeting regularly every month. Houston has the right idea about the staff meeting. It can be made a great help to organized medicine. The chief purpose of a staff meeting is and should be to gain and distribute medical and surgical knowledge to the profession. But in addition to this there are many side issues that can prove most beneficial. The local newspaper editor was present at this meeting and this is a good idea. He can gain some knowledge and naturally he will pass it on to his readers. We can not travel very much farther in the application of modern medicine until the laity has been informed. This can best be done through the medium of the local newspaper. No paper is so important to the education of the general public as the country weekly. At a staff meeting the physician, the dentist, the nurse and the pharmacist should have a seat on the front row. A part of the meeting or another under the direction of the staff should be of interest to representatives of all the organizations of the town and county. To the pastors who must turn the attention of the church to the opportunity it has in doing religion at its very door in the community hospital; to the clubs which are interested in public health and sanitation; and to the teachers who need to know and to impart certain facts to the laity. The staff should prepare certain facts for the county paper that the laity need to know. There needs to be a better understanding between the physician, the nurse, the dentist and the pharmacist.t We enjoyed the staff meeting at Houston. We congratulate them.

The North-East Mississippi Thirteen County Medical Society met at Houston, Tuesday, Sept. 20th, 1932 2 P. M. when the following program was given:

Meeting called to order, Dr. W. C. Spencer, President.

Invocation, Rev. W. C. Steward.

"Some Practical Reflections on the present day Status of the Medical and Surgical Treatment of Goiter," Dr. E. M. Holder, Memphis, Tennessee.

Address, Dr. J. G. Gardner, Columbia, Miss., President Mississippi State Hospital Association.

"Community Hospitals and their Relation to Medical Education," Dr. J. A. Rayburn, Pontotoc. Discussion opened by Drs. Anderson and Caldwell.

"Pulmonary Hemorrhage with Special Reference to Treatment," Dr. W. A. Toomer, of Tupelo. Discussion opened by Drs. J. W. Eckford and B. J. Shaw.

"Diabetes Mellitus", Dr. S. K. Gore, Mantee. Discussion opened by Drs. Deanes and Aycock.

"Pneumonia", Dr. F. L. McGahey, Calhoun City. Discussion opened by Drs. Honnoll and Neel.

Business Session.

Banquet was held immediately after adjournment in the Banquet Hall of the Masonic Building.

RESOLUTIONS

By State Board of Health

Having cognizance of the untiring and valuable services performed by Dr. C. C. Applewhite since the beginning of his association with the Mississippi State Board of Health, the members of the Board, in regular meeting assembled on June 27, 1932, wish to express to Dr. Applewhite their appreciation of his services as a public health official.

There are ample fruits of Dr. Applewhite's labors for the enrichment of the citizenship of those counties in Mississippi having full-time health departments. In these counties, there are striking evidences of practical achievements under his guiding hand. The effectiveness of the public health program owes much to his participation. In the three phases of public health work, education, vaccination, and sanitation, perhaps his most outstanding accomplishments have been in the field of sanitation.

Dr. Applewhite has not only served his church well but has carried religion into his business and wherever he has gone. Integrity, ability, and loyalty are brought into high relief in his life.

It is with regret that the Board learns that Dr. Applewhite will be transferred from Mississippi in October of this year and each member of the Board extends best wishes for his success in the future.

In recognition of the valuable and unselfish services of Dr. Woodward D. Beacham in the field of public health beginning during the period of transition from sanitary supervision to disease prevention when emphasis was shifting from environment to the individual, the Mississippi State Board of Health, in regular meeting assembled on June 27, 1932, wishes to express it sense of personal loss in the death of Dr. Beacham and its appreciation of his services as a health official.

Dr. Beacham wrought long and well in his efforts to benefit his fellowmen and left an enduring monument to his personal character and integrity and to his ability as a sanitarian in the improvements brought about as a result of his energy, fearlessness, and courage.

The results obtained by Dr. Beacham in Forrest County are outstanding and have been used as an illustration of the value of full-time health work perhaps more often than those obtained in any other county; the last time being at the 1931 meeting of the American College of Physicians, Baltimore, Maryland.

Be it, therefore, resolved that this expression of sympathy and appreciation be sent to the family of Dr. Beacham, that a copy be furnished the official organ of the Mississippi State Medical Association, also that this appreciation be spread upon the minutes of this meeting of the Board.

June 27, 1932.

(Taken from minutes of the June 27, 1932 meeting of the State Board of Health).

The Structure of the Pelvic Floor and Their Relationship in the Production of Cystocele and Rectocele

BY GEORGE KIRBY SIMS, B.Sc., M.D.
Laurel, Miss.

In discussing the structures of the pelvic floor and the part they play in the production of cystocele and rectocele we recognize at the outset that we have, in these lesions, very definite anatomical considerations with which to deal, and the production of these pathological entities is the result of a stretching or an overdistention, if you please, of the ligaments and fasciae which constitute the pelvic diaphragms.

The surgical anatomy of these structures is by no means uncomplicated; consequently, in order for one to form a concrete idea of it, as well as that he may fully understand the relationship that exists therein, it becomes imperative either to make a complete dissection of the female pelvis or to study very carefully the anatomical association of these structures through specially prepared specimens. For, though we may be somewhat reluctant to admit it, few of us, indeed, possess the unusual memory or the enviable ability of remembering even as much as the names of these structures, much less their intimate relationship, from merely having seen the best that a demonstration could present to us unless we are constantly associated with them in our surgical procedures.

The female pelvis, as we know, is made up of two parts, or diaphragms; the upper or major pelvic diaphragm, and the lower or urogenital diaphragm. The upper diaphragm is the stronger of the two and consists of the pelvic fascia which envelops the levator ani and the coccygeus muscles, whose attachments are:

Anteriorly: To the postero-inferior surface of the rami pubes (with the exception of a distance of about 2 to 2.5 centimeters just behind the symphysis, which is bare); then along the arcus tendineus, a cord-like structure extending from the back of the pubic arch to the ischial spine on each side of the pelvis.

Laterally: The fascial attachment extends on both sides of the pelvis, reaching across the obturator foramen and attaching itself to the white line, or the tendinous arc, from which these fibers pass inward and downward to the median line.

Posteriorly: Here the fibers come together on the lower end of the sacrum and the coccyx, interlace behind the anus, fuse under the perineal curve of the rectum and end in the perineal body.

The names assigned to the several different parts of this muscle (pubococcygeus, ilio-coccygeus, Ischio-Coccygeus and the pubo-rectalis) are pertinently suggestive of their origin and insertion and form a definite aid in visualizing their position and action. For, from the two side of the pelvis, these muscles slope inferiorly and anteriorly to form a V-shaped gutter which, on contracting, pulls the rectum and vagina toward the symphysis pubis; while the rectal sphincters exert an opposite tug on the rectum simultaneously, thereby closing it.

Below this diaphragm lie the ischio-rectal fossae, the perineal body, the vulva and its glands and the lower, or urogenital diaphragm, which is a triangular, musculo-fibrous septum lying between the public arch and the rectum. This layer of perineal fascia incloses (1) the deep transverse perineal muscles, (2) the compressor urethrae, and (3) the sphincter urogenitalis (O. T. constrictor cunni) which surrounds the vagina. On this septum lie the bulbo-cavernosi, the ischio-cavernosi and the superficial transverse perineal muscles. These end in the perineal body which lies between the rectum and the vagina with its apex in the pelvic diaphragm and is bounded by,

Inferiorly: Skin between the anus and the vulva.

Anteriorly: Vaginal wall and the fossa navicularis.

Laterally: Fascia of the ischio-rectal fossa.

Posteriorly: The anal and the rectal walls.

The function of these diaphragms or the pelvic floor is, (1) In the non-pregnant and the pregnant as well, until the time of lightening, to support the abdominal contents. (2) In the latter part of pregnancy and in labor to guide the presenting part, to assist in the rotation of the head and to bring the occiput to the anterior position.

With the descent of the presenting part, the anterior portion of the pelvic floor is forced against the inferor-posterior part of the symphysis. At the same time the posterior part of the pelvic floor undergoes marked changes, inasmuch as the pressure to which it is subjected pushes it downward and forward, converting it into a thin, membranous-like structure.

The most marked change, however, is that in which the fibers of the levator muscles have been overstretched, as well as a thinning out of the centrum tendineum, in which the wedge-shaped mass of 5 to 6 centimeters in thickness is transformed to an almost transparent structure of 2 to 4 millimeters thickness, displacing it downward to the extent of 2 to 3 centimeters.

It is these particular acts, the marked thinning out of the levator muscles and their downward displacement, along with the downward and backward displacement and a near obliteration of the perineal body, which bring about an overdistention of the structures making up the pelvic diaphragms and contribute to a relaxed perineum with a consequent rectocele formation and its train of distressing symptoms.

The retinaculum uteri, another band of fibrous tissue lying just below the white line and in which the hypogastric vessels, the ureters and the fibers of the bases of the broad ligaments are found, gives rise to four layers of fascia: one going anterior, to the bladder; another lies between the bladder and the vagina; a third interposes itself between the vagina and the rectum, while the fourth is situated posterior to the rectum.

The origin of these leaves forms the basis of the broad ligaments and arises from the inner surface of the upper layer of the levator fascia. Anteriorly, it is carried bilaterally to the pubes to form the pubo-vesical ligaments. Posteriorly, it attaches itself to the sacrum, to form the uterosacral ligaments; while its lateral extensions give rise to the broad ligaments.

One may, therefore, liken this construction to an ordinary wheel, visualizing the cervix as the hub, the fibrous tissue strands or ligaments as the spokes and their pelvic attachments as the felloe.

So, in labor, especially when the cervix is pulled upon, as is frequently the case in any operative procedure before dilatation is complete, these ligaments or spokes becomes stretched, torn or broken from their pelvic or cervical attachments, with a consequent downward displacement of the hub, resulting in a complete anatomical and physological disarrangement.

These fascial leaves or ligaments form the only support of the cervix, bladder, vagina and rectum and preserve their relationship to each other and to the pelvic planes. It is a disturbance of this relationship and especially that relative to the vesical fascia and its ligaments, such as may be, and is too frequently, brought about through the application of forceps with injudicious transaction upon them, by marked disproportion between the fetal head and the diameter of the birth canal, malpositions in labor, bearing-down efforts during the first stage of labor, or by a long drawn-out second stage whereby the propulsive efforts of the uterine contractions have weakened the supports of the bladder, which contributes most largely to the production of cystocele.

SUMMARY:

1. Cystocele and rectocele are, primarily, products of labor.
2. They result from a stretching or an overdistention of the structures of the pelvic floor.
3. Bearing-down efforts on the part of the parturient during the first stage of labor constitutes a definite factor in the development of these lesions.
4. The administration of pituitrin and the pituitary extracts, in the absence of a definite indication for these adjuvants, is not infrequently accompanied by such conditions.
5. Malpositions in labor, such as the persistent posterior occiput, face and brow presentation, are largely responsible for these pathological entities.
6. A prolonged second stage in which the propulsive efforts of the uterine contractions have weakened the vesical supports plays an important part in cystocele formation.
7. Disproportion between the passenger and the passages is a factor to be considered in the production of these anatomical disturbances.
8. Unfortuantely, they result from improperly applied forceps and more especially from injudicious traction thereupon, particularly in those instances in which cervical dilation is not complete and the occiput not rotated to an anterior position.

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Digestive and Infectious Diarrheas In Children*

BY T. A. MOORE, M.D.
Byhalia, Miss.

*Read before the regular Quarterly Meeting of the North Mississippi Medical Society, Holly Springs, Mississippi, Wednesday, June 15, 1932.

In selecting this subject I realized that any one phase of it would be sufficient subject matter for a symposium. It is presented to this society, not to impart any knowledge of its contents, but to introduce this most important condition that we all have to see and treat almost daily, especially during this season of the year. It is a disease that forces the older physician to realize, he will never become perfect, and cause the younger doctor to wonder if he wasn't released from school with his diploma and yet lacking in his ability to meet the demands required of him.

Diarrhea of its self is only a symptom, but one of such tremendous importance that a review of its various causes and characteristics is necessary. It is one of the most frequent and possibly the most serious disorders of infancy and early childhood. The part which it plays in the general mortality of early infancy has been estimated from various statistics to be 18 to 30 per cent in the first year of life, accounts for more deaths in the less-than two-year-group, than all the other infectious diseases of childhood combined.

For a general classification we divide diarrheas of children into Digestive Disturbances and Infectious, or inflammatory.

Clinically the differentation rests upon the greater severity of the local symptoms and the constitutional involvement. As simple diarrheas, so seeming in the beginning will change into a more severe type plus infection, that is infective, or inflammatory in character. It is still an unsettled question as to what extent the diarrhea is chemical or bacteriological respectively at its onset.

Age is an important predisposing factor, as the greater majority of cases occur during the first two years of life, and mostly during the summer months.

The incidence and mortality seem often directly proportionate to the intensity of the summer heat.

The excessive heat during the summer months not only has a depressing effect on the child, lowering its digestive ability, but favors the growth of bacteria in the food. This growth of bacteria produces a toxin which acts as an exciting and irritating material. It is probable that in some instances these toxins are produced by bacterial action upon milk before it is taken into the childs stomach. From this viewpoint milk that has been contaminated by improper and unsanitary handling also defective and late cooling systems favor the growth of bacteria to such an excessive rate and amount that sterilization will not destroy their toxic substances even though the active bacteria are killed, and toxins from this grade of milk are capable of producing digestive upsets.

The use of impure milk is so important that groups of cases have been traced to a certain milk supply. When contamination of milk began to be appreciated, it was thought that the real cause of diarrhea had been discovered and, with the furnishing of the child with pure, pasteurized or sterilized milk, the problem would be solved. While the mortality has been greatly lowered by the use of better milk under hygienic surroundings, yet the mortality is still alarming.

From my own limited observations, artificially fed babies constitute a greater per cent of diarrheas in children. It will be remembered that less than five per cent of the cases of diarrheas are in breast fed babies, and fatal terminations are very rare.

We see in our rural sections, especially among the uneducated white and the ignorant negro, that artificial feeding is poorly done, and certain food mixtures are made up under the worst hygienic surroundings and with no knowledge of food values or the ability of the baby to digest foods, and as a result the infant falls into a condition of malnutrition, loss of vitality, and is an easy prey for diarrheal diseases.

There is no doubt that with a lowered resistance, a loss of body tone, a sluggish function of the stomach and small intestines, a loss of appetite and an increase in the bacterial flora. The hydrochloric acid of the gastric juice is decreased, as shown by Marriott, Davidson and Harshman, causing a depression of the gastric secretions, a delay of the emptying time of the stomach leaving a residual of undigested and unabsorbed food which may create an irritating end product capable of increasing peristalsis.

Breast fed babies are subject to the same element of overheating by too many clothes, too long exposure to direct sun rays or being kept in a hot room that is poorly ventilated and overcrowded. Davidson has shown that there is a reduction in the activities of the duodenal enzymes and secretions of the duodenum in these babies. Under such conditions the growth of the normal bacteria present in the intestinal canal, which have been demonstrated to be the bacillus bifidus, bacillus acidophilus, and to a less degree the bacillus coli and the bacillus lactis aerogenes, these may take on increased multiplication and virulence producing toxins which act locally and by absorption sufficient to produce a diarrhea. Well do we appreciate the fact that the character of the mother's milk is subject to variations of as wide or even wider flucuations than the milk of mammals according to her diet. Broadly speaking a mother's diet should come within the limit that would be ordinarily regarded as a balanced diet for her particular economic, social and physical requirements. Such conditions are oftenest met in the congested urban centers, however, the rural and semi-rural sections are not exempt.

As to the eruption of teeth, which I believe most of the profession agree with Wilson whom I quote as follows: "Teething should not be accorded a place as a predisposing cause. I mention it because the diagnosis, teething, is responsible for so many deaths. It is true that during the acute teething period digestion is weakened and foods which previously agreed may disagree. Tolerance is lowered, but it is undigested food, not teeth, that causes the increased peristalsis. Many mothers think it is quite natural that diarrhea should accompany teething and allow it to progress uncared for, whereas, any looseness developing at this period demands even more strenuous efforts to correct it at once. Teething, then is only a predisposing cause through a lowered tolerance for foods."

As an etiological classification I wish to mention them as outlined by Griffith:

(1) Diarrheas Due to Locally Acting Mechanical or Chemical Causes.

(2) Diarrheas of Toxic Origin (Acute Gastroenteric Intoxications).

(3) Diarrheas of Nervous Origin.

(4) Diarrheas of Metabolic Origin.

(6) Diarrheas of Inflammatory Nature.

It is not necessary to comment or elaborate on this outline as to each individual heading. Often times we see the child after the diarrhea has existed for some days, and a real true classification cannot be made. In fact there has been so many different classifications as to the type and cause of this condition that we would be running around in a vicious circle if we tried to make a definite statement as to the exact cause which originated the trouble.

Nothing new can be presented on symptomatology and diagnosis of this condition, since symptoms have always been about the same, and diagnostic ability, as a rule, need not be acute to distinguish this complaint.

In the functional type which is the most common and constitutes about 65 per cent of cases. The form of diarrhea is simply one of gastrointestinal irritation, caused by some undigestible or unsuitable food. The onset is rather sudden, there is as a rule abdominal pain and distention with moderate fever. In a few hours, frequent greenish stools, with craving for water and vomiting immediately after drinking it. In the more severe or infectious types the symptoms are much more acute the number of stools are twelve or more in the twenty four hours. Tenesmus, straining, mucus and blood in the stools. Pus or pseudo-membrane may be present.

Menigeal symptoms, varying from stupor and coma to restlessness, muscular twitching, and convulsions often usher in the more toxic cases. Prostration and collapse in the later stage of the disease.

Thirst is extreme from the beginning and soon that awful picture, so familiar to all of us. of dehydration-sunken eyes, the hollow cheeks, the pinched expression, the scaphoid abdomen with its loose, inelastic dry skin, and the rapid breathing of hyperpnea of acidosis. Toxemia, and not the number of stools, is the criterion of the severity of the case.

It is impossible from the symptoms to determine what form of organism is the exciting cause of the disease in each individual case. Microscopic examination of the stools is of little assistance in differentiating the various types, unless the streptococcus is the cause, in which case they are usually present in large numbers and easily recognized.

Differential diagnosis—on account of the bloody stools, intussusception is not infrequently confused with infectious diarrhea, the usual mistake being to overlook the intussusception and call it infectious diarrhea. The onset in intussusception is sudden, without fever or diarrhea at first. Blood appears in the stools soon and abdominal pain with tenesmus is marked. Vomiting is extreme. The abdomen is not scaphoid but distended, and a tumor may or may not be palpated. Acute appendicitis is sometimes accompanied by a diarrhea which makes the diagnosis difficult or less likely to be considered, particually when it occurs in the midst of a summer-diarrhea epidemic.

We should always remember, when called to see a case of diarrhea in children, not to fail to make a careful and complete physical examination, keeping in mind the fact that it may be secondary to some parenteral infection, such as otitis media, mastoiditis, sinusitis or pyelitis. Never overlooking the value to be derived from an inspection of the ear drums, a microscopic examination of the urine and last but not least a rectal examination, gently done.

Treatment depends upon the type you are dealing with. Prophylaxis is the most important thing to consider first, and the following measures should be stressed:

(1) Encourage maternal nursing.

(2) Educate the mother in all matters relating to the care and hygiene of the baby.

(3) Adequate supervision of the milk supply.

(4) Constant supervision of the artificially fed infant.

(6) Sanitary surroundings with proper ventilation of the homes.

These measures of prevention are worth more than all the curative agents if they can be gotten over to the laity. In no other field are the opportunities for preventive medicine and life saving, by simple, common sense care of babies so great.

This advice should be given before the baby is born, the expectant mother should be placed in the best possible surroundings. The physician should take time to explain to the mother, to be, the importance of breast feeding at regular intervals, and the proper care of the baby during hot weather. Tell them of the danger of overfeeding in the hot summer months. And that all milk unless certified should be sterilized in hot weather, especially. All the water the baby drinks should be boiled. Ice cream, fruits etc. from street venders should be prohibited. Babies should not be allowed to crawl around in filth and dirt. The best insurance for the baby is a clean floor covering provided for him to play on.

In treatment of the attacks of diarrheas we have three conditions to combat, toxicosis, dehydration and acidosis. The overcoming of these grave conditions means successful treatment. And to do this each one has his own tried measures. The essential principles of treatment are: (1) the elimination of the poison, whether it be 'bacterial or food toxin', (2) to counteract the acidosis by medication and food, (3) to overcome the loss of fluids from vomiting and diarrhea, by supplying fluids in various ways, (4) to treat symptomatically hyperpyrexia, collapse, tenesmus, convulsions, or other symptoms as the individual case may need.

I feel that diet is the important factor in the treatment of diarrheas. Medicines are of secondary importance. The three drugs that I have used most successfully are castor oil, bismuth and opium. As an initial purgative given at the beginning of the attack and not 12 to 24 hours later nothing has been more effective than a big dose of castor oil. However, later in the disease it should be used with great care, as the increased peristalsis caused by its administration may do harm to the already inflamed mucous membrane of the intestinal tract.

Bismuth subcarbonate in full doses is believed to be helpful in checking the diarrhea, also for its healing effect exerted on the inflamed mucous membrane. Opium, like a two-edged sword should be used cautiously and not as a routine, however, after the intestinal tract is free of toxins, and the diarrheas is still excessive, the tenesmus great and restlessness extreme, some form of opium acts well in allaying these symptoms.

The complete withdrawal of foods may be necessary, depending on the severity of the symptoms, but should never be longer than twelve to twenty four hours, unless there is persistent vomiting. The body fluids should be maintained, if there is no vomiting water may be given by mouth during the starvation period as often as the baby will take it. When vomiting is present, or in severe dehydrated cases fluids may be supplied by mouth, subcutaneously, intravenously or intraperitoneally. The intraperitoneal route is by far the best and safest procedure. The solution used is normal saline with 5 to 10 percent glucose, and given by gravity after the solution is heated to 110 degrees F. The needle is inserted an inch below the umbilicus in the midline at an oblique angle, pointing upward. The amount given will vary with the degree of dehydration and the ability of the child to take it up. The solution is allowed to run in until the abdominal veins become slightly distended. Always be careful not to let the solution flow in too fast and cause an embarrassment of respiration and circulation. This may be repeated in 12 to 24 hours if necessary.

Next in importance to supplying fluids and eliminating the toxins, is the problem of feeding the baby so as to maintain its resistance to secondary infectious and to be able to regain and keep his weight up to normal. Since there are so many formulas and brands of milk on the market I will not attempt to go into detail about their uses, merits and demerits. But will only mention three types of milk that I know to be good and very satisfactory in my practice. They are (1) diluted cow's milk, (2) Protein Milk, (Casec) (3) Lactic Acid Milk. All of these I am sure are familiar to all, as to manner of preparation and use.

SUMMARY

(1) That diarrheas are never to be regarded as a simple malady, remembering that the mildest onset may in a short time be so grave in character, that in spite of all measures terminate seriously.

(2) The child-under-two-years constitute the greater number of cases. That hot weather, unsanitary surroundings, artificially fed babies and micro-organisms are factors that work almost inseparable as etiological causes.

(3) All cases presenting diarrheal symptoms should be examined other than the digestive system, as the exciting cause may be far removed from the gastro-intestinal tract.

(4) Proplylaxis should be stressed more, expectant mothers advised relative to proper care of infants and importance of breast feeding.

(5) Children recovering from attacks of diarrheas, especially those of severe infectious types should be watched after for sufficient time to be certain they have been restored to their normal weight and able to resist infections that might prey on them due to lowered vitality. Hence, it behooves us, as general practitioners, to try and get the parents to realize the importance of properly safe-guarding the child and to co-operate with us, so that the best results may be obtained.

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The attention of the medical profession is called to the announcement of the Fourth Annual Assembly of The Southern Surgical Congress which will be held in Atlanta, Georgia, March 6, 7, and 8, 1933.

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Executive Secretary.

Radium Therapy with the Report of a Few Cases

BY W. H. ANDERSON, M.D.
Booneville, Miss.

The purpose of this paper is not to give an authoritative discourse on all the pathological conditions in which radium is indicated or may be used to advantage. It is to try to call your attention to the help radium may be to the practitioner in our territory.

Radium was discovered about thirty years ago by Mme. Curie and her husband. For the last ten years great strides have been made in the application of radium to the relief of human suffering. In our ipinion, it has not yet reached its height of usefulness in the hands of the medical profession. All praise and honor to Mme. Curie, and to her husband who worked with her so devotedly in the discovery of radium. It has not been a very plentiful element, there being only about eight or ten ounces in existence at this time in a useable therapeutic form. It is very expensive to obtain. But a tube of radium is supposed to last twenty-four hundred years. Its spontaneous and continuous emission of rays every second of the day and night makes it very interesting. It gives off three types of rays—alpha, beta and gamma. The alpha rays are cut off by very little screening, the beta rays are largely obstructed by the wall of the platinum needle, the brass tube and the rubber stall, while the gamma rays, a small percent, will pass through six inches of lead. Distance is of the greatest importance in the application of the gamma rays. The gamma rays are the principal ones used.

The most practical form of radium for this territory is the ten milligram needles. Fifty miligrams is sufficient to handle the average case although greater amounts are very desireable for some cases. In the earlier days of radium therapy its use was largely palliative, but now it is a curative means and also prophylactic. I doubt if there is a practitioner in this audience who does not see from one to a half dozen cases each week who really need radium. I am quite sure that I am now treating this number of cases. I have had my own radium and used it regularly for eight years. With this my experience is, of course, limited. But I wish to call your attention briefly to some of the conditions I have treated with radium giving you a report of just a few cases.

Potential epitheliomas of the face, ears and neck respond splendidly to radium therapy. Itching and burning of the persistent "rough spots" indicate that treatment should be given. X-Ray will also cure these "risky lesions," but radium is much to be preferred. The average lesion of this type is usually relieved by three to six hours treatment with fifty milligrams. The tube containing the needles is wrapped in enough gauze to remove the radium one-quarter to one-half inch from the surface of the lesion. These spots should be observed for at least twelve months and treatment repeated if the lesion returns. Cancer of the anterior half of the tongue responds magically to radium. Here it is best to bury the needles around the margin of the lesion so as to cross fire. Carcinoma of the posterior half of the tongue will yield to radium, but the lesion is much more grave. Eight to twelve hours is required with needles buried. It is important to bury the needles well so as to prevent burning the mucous membrane of the mouth and making it very painful. The treatment may be repeated in two to four months, if necessary. Carcinoma of the lip responds well to radium therapy; six to ten hours with fifty milligrams in the moderate case. Carcinoma of the mucous membrane responds more stubbornly and more radium is required. Radium in the nose following the removal of polyps gives splendid results in a big percent of cases. Place the fifty milligram tube with gauze rolled around it on the inside for the three hours and then three on the outside. Radium is the treatment of choice for cancer of the eyelids. Here you have to be very cautions to give the radium as much distance from the eye as possible. Two to four hours at a time is best and give four to six weeks between treatments has been my plan. The effects of radium lasts much longer than was once thought.

Small lumps in the breast may well be treated by surrounding them with the five ten- milligram needles buried well under the skin for twelve or fifteen hours, and then three to four weeks later enucleate the entire breast. This gives a good average of cures if the radium is used early. When the cancer cells pass beyond the breast, it is like chasing a rabbit in a brier patch to obtain a cure.

Hemangiomas, wherever found, respond well to radium. The types that are elevated are the most ideal for radium therapy. Press your finger on the affected area; if it bleaches and the color comes back when the finger is removed, you may expect good results with radium. It is hard to say just how much will be required; just use small doses until the color is bleached out. Be very slow to use the knife on the tumor type of hemangioma.

Ex-opthalmic goiter is amenable to radium therapy. Keep in mind the parathyroids in applying the radium tube. The object to keep in mind is to cut down the excess output of the gland. Radium may do the same work as the knife, the extirpation of a part of the gland. Radium may well be used in conjunction with surgery, sometimes to put the patient in better condition for an operation.

Within the last ten years radium has almost entirely replaced surgery in carcinoma of the cervix. In the earlier days of radium it was used just as a palliative treatment in those

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cases that were entirely too far advanced for surgery. Now radium is the treatment of choice par excellence. It is important to make a careful pelvic examination before using radium. Pus tubes, cystic ovaries, tubal pregnancies, and pedunculated fibroids are contra indications to radium in the cervix or the uterus. If the coast is clear, in terms of the pelvic pathology, then the radium tube may be placed in the cervix so that the middle of the tube with the fifty milligrams may be about the middle of the cervix. In the average case the tube should remain from thirty-five to forty hours. If the patient is very anemic from loss of blood, a transfusion should be given first or only eighteen or twenty hours at first. If the cervix has been lacerated and the lips are everted, it is often well to bury the needles in the worse affected areas. Carcinoma of the body of the uterus yields well to radium, but many good surgeons yet believe in total histerectomy as the preferred treatment. Radium therapy also has a splendid future in the soft, tender, enlarged, sub-involuted, pre-menopause, leaky, future cancerous uterus. It is the type that leaks the woman to exhaustion. She hardly gets over one menses until the next is on. Thirty hours with fifty milligrams gives a wonderful result. It shrinks and hardens and tones the uterus. It hastens the menopause and makes it easier, if there is any difference. Be on the watchout for this type of case and you will often head off cancer before it begins. Dysmenorrhea often gives way with seven to ten hours with fifty milligrams. Menorrhagia in the young girl responds marvelously to ten to twelve hours radium in a large percent of cases. The symmetrical fibroid up to the size of a cocoanut melts before radium like snow on a hot rock. The caruncle responds well to three to six hours of fifty milligrams in the tube. These by no means are all the lesions that may be treated successfully by radium. But you must conclude that you have some of these cases with you almost daily.

It is claimed that abnormal cells are sensitive to the radium ray and are five times as easily destroyed as the normal healthy cell. Some believe that the action of radium on the small blood vessels closing them and cutting off the food supply to the abnormal cells, or cancer, causes their death. It is probably a combination of both. Anyway, the art in using radium is to use enough to destroy, choke or cause to die, the abnormal cells, but not to injure the normal ones. The nearer we get to the border line of injury the better, we believe. We should, however, be exceedingly cautious not to get a radium burn. Better be rather conservative than to have a burn, for when once you have one, you have it.

We should like to emphasize the importance of taking any radium case in charge for a year; look after the case; repeat the treatment if necessary, and give special attention to his or her general care. The cancer patient should have every care to improve the health gener-

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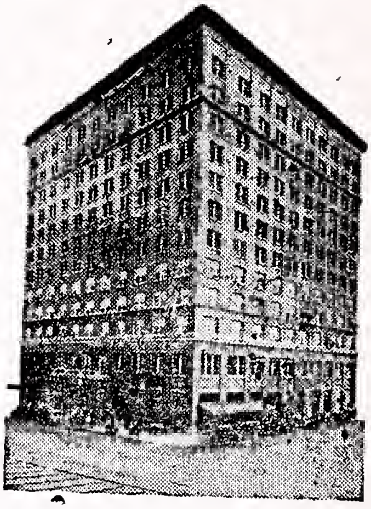

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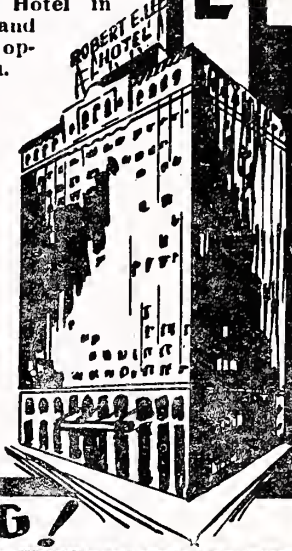
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I am giving a brief report of a few cases selected more or less at random, but from different classes:

Miss E. V.; age 22, health generally very good, had suffered four years with dysmenorrhea. Treatment twelve hours fifty milligrams intra uterine. Patient has had no trouble since.

Mrs. M. C.; age sixty-five, carcinoma of cervix, grade two, some sloughing and constant discharge with odor. Fifty milligrams in cervical canal Sept. 1, 1924. Discharge and bleeding stopped; patient improved. In March 1925 she began to have slight color. Examination revealed some involvement on one side of cervix. Radium was used again for eighteen hours. Patient still living and well.

Miss B.; age 24, menses profuse; flow for eight to ten days and had been for three or four years, had every time of medicine by several different physicians. Radium 12 hours in uterus fifty milligrams 10-1-30. Patient is regular about four to five days; blood from 35 per cent hemoglobin up to normal, in good condition every way.

Baby Mc. age 10 months. Tumorous hemangioma of left vulva. One to two and a half hours radium over a period of one year. It is now difficult to observe the difference in color of the vulva and the left is but very little larger now. Fifty milligrams was used in tube with gauze around it.

C. B. male, age 38. Both sides of nose obstructed with polypoid growths and had been for about three years. Twenty-four growths were removed, about a dozen from either side. Nine hours radium was used, three inside and an hour and a half outside on either side of nose. Nine months later both sides of nose is well open and no sign of return of growths.

Mrs. J. M. C. Age sixty-five. Carcinoma of cervix; Dr. Robinson of Memphis made diagnosis. Patient had been bleeding for about six months, crater formation beginning. Physical condition rather poor. Twenty six hours radium used, eighteen hours three months later. Patient in good health now after eight years.

F. P. age 45, male, laborer. Had nose bleed for ten or fifteen years, just break loose and bleed, no cause to be found, was unable to work from loss of blood. As soon as blood would increase it would break loose again. Three hours radium used in nose over area of bleeding, six weeks later two and one half hours. After fifteen months patient is fine and no more bleeding.

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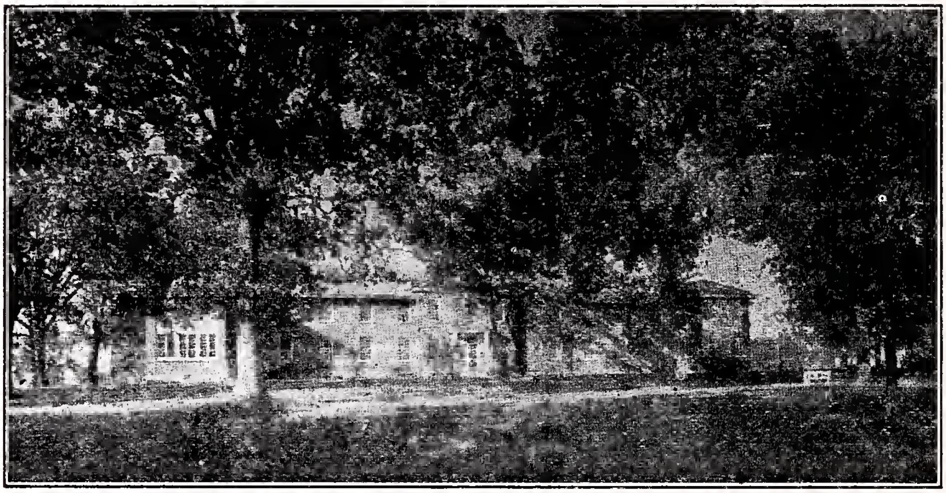

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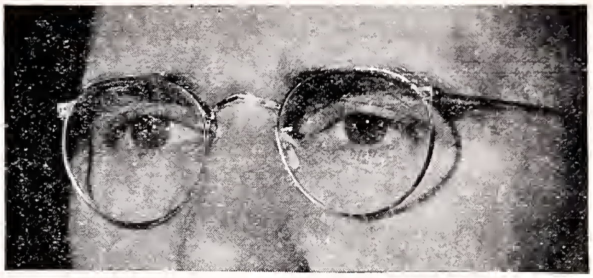

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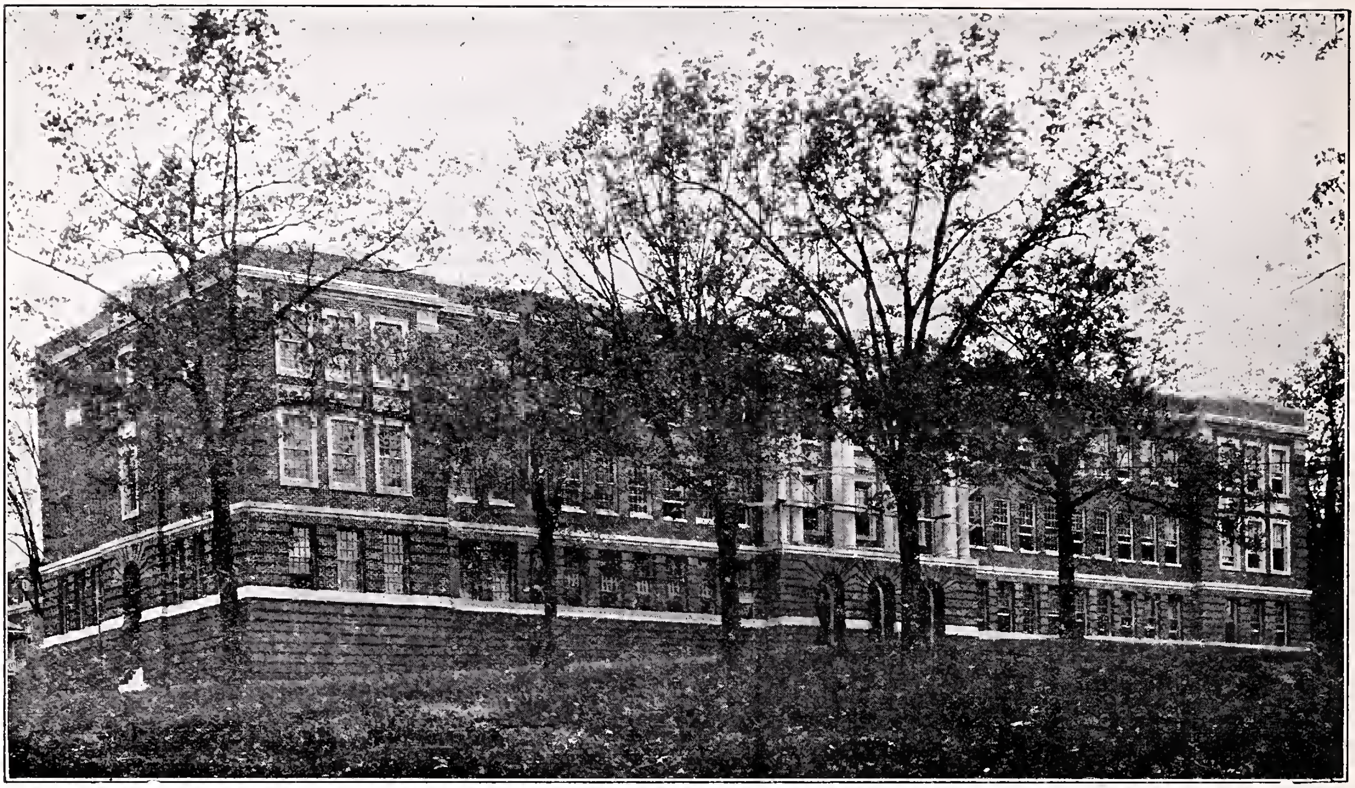

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An open book, an open fire,
Get something out of these

There are such joys of heart and mind
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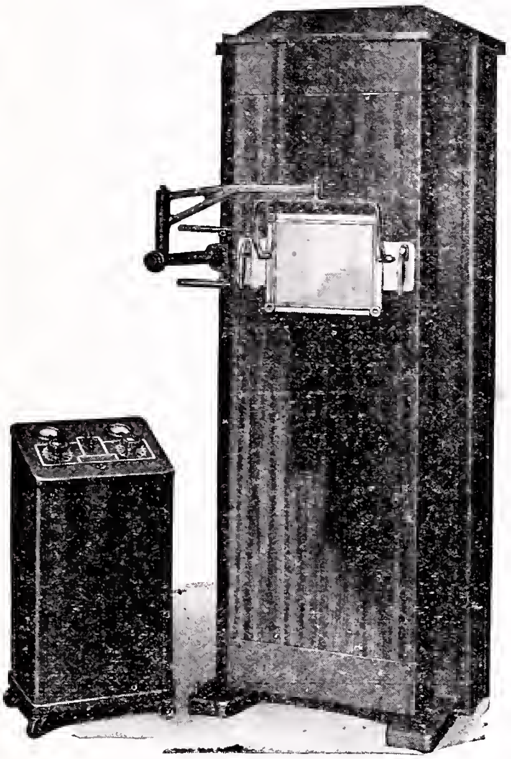

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THE MISSISSIPPI DOCTOR

OFFICIAL ORGAN OF THE NORTHEAST MISSISSIPPI 13-COUNTY MEDICAL SOCIETY
—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

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You will be pleased with our Ole Miss Department. We thank W. D. Beacham for his work in editing it.

Send us a few new subscribers for The Mississippi Doctor at one dollar per year, our depression offer.

Dr. McCord's lectures on obstetrics are fine. Better obstretics we will always be in order.

Dr. J. A. Rayburn of Pontotoc has a most interesting discourse in this issue on the Community Hospital. Dr. Rayburn is one of the early advocates of this institution. He served for four years as Superintendent of one of the state charity hospitals. But he is still very strong for the community hospital. You will read his paper with much interest.

Southern Medical Association meets in Birmingham in November. This will be convenient for our society. It should be well attended. Birmingham will have a good meeting. It is well located and it knows how to entertain. In times like this it is well to keep the meetings near the center. The attendance will be better. For our next meeting of the Southern we vote for Memphis. You can't surpass Memphis for a convention town. It has a medical atmosphere and Southern hand of cordiality that makes every one want to go back.

The committee on legislation and public policy did some work, some good work. It some times does its best work by not doing some things that some want. A report was made at the state meeting.

Through the kindness and courtesy of the Editor, Dr. Anderson, and the Dean of the Ole Miss Medical School, Dr. Mull, arrangements have been made whereby the readers of The Mississippi Doctor will be able to know more about the faculty of the University of Mississippi Medical School. The students and faculty members of the University of Mississippi are proud of these men, and we shall be happy for you to know them better.

The annual meeting at Ole Miss is a good custom. Every physician should be proud of his university and especially of the fine medical department we have there. For a two year course it stands at the top. Many worthy young men can go to Ole Miss who could not go out of the state on account of the added cost. The Medical profession of the state should be very grateful to Dr. Mull for his untiring efforts in saving the school and keeping it on a high plane. Except in special cases for special reasons, Mississippi's young men should certainly take their first two years in medicine at Ole Miss. As long as Dean Mull tells you it is all right you need not fear.

Our five state charity hospitals are serving but a very limited portion of the state. They are political footballs that have now outgrown their day of usefulness. They must give way to bigger plans, more efficient plans, and a plan that will be more economical to the state as well as rendering better service to the entire population.

The medical profession is being put to a most grilling test at this time. No other profession is called upon to make such sacrifices as it is at this time. Thus far it is meeting the challenge in fine style. It is going forward in the progress of the science and it is giving service to a needy people many of whom can not pay. No profession has a higher calling than ours. Let us keep up our courage. Let us keep on keeping on and may be the mountain will move.

The community hospital can and must learn to give more and better service for less money. It is already in the lead along this line, but when so many products are very cheap it can do better. The hospital authorities must teach the people of the town and country, the churches and the different organizations to make small donations so that the hospital expense may be kept down. When a person gets sick then is when he needs help. While he is well he should make a small donation to the hospital. He can make it an insurance for him and his family. One dollar from each family in a county in something that the hospital can use will sove the problem along with a ten cents per capita donation from the state. This is easy. It would not be hard to do. It is the principle, it is working plan, that we must come to. We don't have to study past records and what hospitals have done. These are all right, but in the past we have not fully met the problem. Let us get busy making hospital history and not put in so much time figuring what hospitals have done. Make the move to get a dollar from each family. Two bushels of meal, a bushel of potatoes, a ham of meat, some chickens, some fruit. Let the hospital have a storage house to take care of it. This is sensible. It can be done. Let us begin now.

Dr. Gardner, President of the State Hospital Association, is taking an active stand for the community hospital. He is bring out some interesting facts about our hospital problem. We are glad to see him taking this interest. The small hospitals, in fact, all the hospitals need to be behind the move to distribute the hospital funds over the state on a per capita basis.

There are only eight state charity hospitals in the United States. Mississippi has five of them. Last year the appropriation for them was two hundred and fifty one thousand three hundred and eighty-five dollars. Nearly forty three per cent of this was spent in the five counties in which the hospitals are located. Just to make it easy, more than twenty thousand apiece for these five counties and less than two thousand for the other seventy seven. If all the counties should receive twenty thousand apiece, it would mean more than a million and six hundred thousand dollars. In 1931 the total appropriation for the five hospitals was $251,385. Total salaries per month, $3,425.93, total for the year 1931, $41,111.00. Even at the very low valuation of one half million dollars for the five hospitals and their equipment, the interest at six per cent would amount to thirty thousand dollars. The repairs and upkeep of the buildings and equipment no doubt cost another thirty thousand per annum over a period of years. So we are out one hundred thousand dollars for salaries, buildings and equipment before we treat a patient. This would keep fifty thousand patients for one day in hospitals at two dollars per day. The average cost per patient for the five hospitals for 1931 is one dollar and ninety five cents. It is very doubtful if all the patients spent twenty four hours in the hospital and is quite certain that they do not receive as good treatment as they do in the community hospitals. And then there is a big expense to the patient, to ones, who go any distance for travel and other items. They are carried away from their loved ones. They do not have the personal attention they would have. They have the danger of the time element. By developing the community hospital you develop a small medical center in each county or in each two or three. It is our biggest factor in raising the general batting average of the medical profession. It is the best piece of money economy and social economics that has ever been offered the state. Our state funds for the unfortunate sick must be distributed to the counties on a per capita basis. At ten cents per capita it would take two hundred thousand dollars or about twenty five hundred to the county. This would be enough to make out with very well. We should not encourage charity and we should study to prove ourselves good medical economists, good for ourselves and just as good for our patients. We must make our profit on volume of business in the future. We do not try to make a profit out of hospitals, usually do not. We can learn to handle patients cheaper than we have been. We can not be governed by the cost in the past altogether. We can leave off some of the frills and use the plain essentials. We should be able to make three dollars a day take care of the average patient, the acutal cost in the community hospital. The state then would not be out anything for salaries, no repairs on building, and no thirty thousand interest or loss in taxes. This hundred thousand that the state spends before it treats a patient would take care of thirty three and a third thousands for one day at three dollars. The medical profession must rise to its responsibility. It must do its part so well that no one can be dissatisfied. The state must do its duty and take advantage of its opportunity for service to the poor people of the state through the community hospitals.

Booneville is delighted to have Dr. James R. McCord, Professor of Obstetrics and Gynecology, Emory University School of Medicine for a course of lectures. This is a long step in the right direction on the part of the State Board of Health. We commend Dr. Underwood in bringing this post-graduate school to the profession. Dr. McCord is thoroughly grounded in his specialty. He is indeed worthy and well qualified. His teachings on obstetrics is sound Gospel. You may follow them and fear no evil results. He has had the training. He has had the experience. He is a fine instructor. This type of post graduate teaching for the medical profession will fit in fine along with the development of the community hospital. Dr. McCord is giving his lectures at the Methodist church. They are being attended by about thirty physicians of this section. They seem to be very appreciative of this piece of service on the part of the State Board of Health and Dr. McCord. These lectures are on a most important subject. Better obstetrics is always in order. This last word from an authority on this specialty at this time brought out to the profession should be doubly appreciated. The small town and country practitioner are having it hard at this time, more so than any profession we know. They have kept up courage. They have worked nobly to render a needed service. They deserve to have this service brought to them. When it comes to them they should avail themselves of it and should appreciate it. We believe they do very deeply appreciate it. We are very anxious to see this type of post graduate work brought to the profession in other lines as physical diagnosis and children's diseases etc. We want to assure Dr. Underwood that this is one of the greatest pieces of services he has ever brought to the medical profession of the state. We want to ask him to give us another man like Dr. McCord on another subject and not to wait too long.

On the part of the physicians of this section we want to thank the Methodist church for the use of a room for the delivery of these lectures, and we want to offer Dr. McCord a standing invitation to return and give us his course of lectures again.

The following doctors in this section have enlisted for the class:

Drs. C. M. Murry, W. M. Marsh, Ripley; R. B. Cunningham, W. W. Strange, R. C. Cunningham, S. L. Pharr, L. L. McDougal, W. H. Sutherland, W. H. Anderson, W. V. Davis, Booneville; R. G. Dabbs, Shannon; H. A. Stokes, Guntown; E. J. Green, Chalybeate; F. C. Boren, Ratliff; R. B. Caldwell, M. B. Rhodes, Baldwyn; J. T. Dabbs, Nettleton; N. W. Nanney, J. T. Senter, Fulton; H. G. Waldrop, Dumas; A. L. Gregory, C. C. Pyle, Saltillo; R. E. Honnoll, Rienzi; I. B. Trapp, S. E. Eason, H. P. Boswell, New Albany; A. F. Whitehurst, R. T. Brown, T. P. Haney, Sr., Iuka; N. R. Weaver, Mooresville; J. R. Hill, Corinth; Chas. E. Spencer, W. B. Holland, Verona; J. S. Wheeler, N. C. Waldrep, Tishomingo; K. F. MacRae, Belmont; W. H. Eason, Tupelo; F. F. Hansell, Okolona.—Booneville Independent.

PHILIP LEE MULL, B.S., M.D.
Dean of Medical School
Professor of Anatomy

Born and reared in Indiana, Dr. Mull received the B. S. degree from Valparaiso University, Valparaiso, Indiana, in 1895; and his M.D. from the Kentucky School of Medicine, Louisville, Kentucky, in 1898. He then engaged in the General Practice of Medicine in Indiana from that time until 1920. At which time he enrolled as a special Student in the University of Louisville Medical School, Louisville, Kentucky, and did the work given in the freshman year. Upon completion of these courses, he studied Histology in the University of Indiana Medical School, Bloomington, during the summer of 1921. Two summers later he completed the Post-graduate course in Operative Surgery on the Cadaver in the University of Illinois Post-graduate Medical School, Chicago. The following summer, 1924, Dr. Mull studied Bacteriology in University of Michigan Medical School, Ann Arbor. During the summer of 1925, he studied Clinical Microscopy in University of Colorado Medical School, Denver; and the following year he returned to the University of Michigan Medical School to spend the summer studying Pathology. Dean Mull spent the summer of 1927 making Ward Rounds in the Department of Clinical Neurology, Massachusetts General Hospital, Boston.

Dr. Mull became a member of the faculty of the University of Mississippi Medical School in 1923 having accepted the Professorship in

Anatomy, and having served as Professor of Anatomy in the University of Louisville Medical School from 1921 until that time. Since then he has been Professor of Anatomy at the Ole Miss Medical School and became Dean in 1930.

Dean Mull is a Member of the American Medical Association, the Southern Medical Association, and the Mississippi State Medical Association of Anatomists since 1922. He has had numerous honors conferred upon him and is a member of Phi Chi medical fraternity.

Dr. Mull puts himself body and soul into his work. He loves Anatomy and one's association with him means much. Those men who have attended the Mississippi Medical School are proud of the excellent course which they have received under his instruction, and boast of the fact that they had Anatomy under Doctor Mull.

In addition to being a first-class Anatomist, Dr. Mull is a Naturalist and Humorist of no mean ability.

Ole Miss Medical Department

BY WOODARD D. BEACHAM

The members of the Class of '36, which is the 29th class of the Ole Miss Medical School, have set forth on the rough and rocky road that leads to an M.D. degree. They, as only medical men can know, have much in store for them. Their days as first year medical students will be filled with books, bones, and a full share of boners. And henceforth they shall crave the company of those persons interested in the study and practice of medicine, and will find great delight in being in the presence of Doctors.

These young men have been told much about Mississippi's Medical School and they will learn more. They will be proud of its history; the many advantages that it offers; and the records made by its students in other medical schools, before state examining boards, and the success achieved by them as practitioners of medicine. They shall strive to be worthy of the Medical School which has meant much to Mississippi and which is worthy of the strongest of support.

The Ole Miss Medical School opened its portals for the 29th time not to admit the largest number of students in the history of the school but to permit the entrance of a group of young men determined to secure a medical education. The two classes, which fall a little short of their capacity, would be no doubt overflowing if times were normal, since a number could not come to school because of financial difficulties. Those in authority state that quantity and not quality is lower; furthermore, that the work done this year should be the best that has ever been accomplished.

The Ole Miss Meds. thoroughly enjoyed the meeting of the North Mississippi Medical Society and derived much benefit therefrom. Great ambition is inspired on the program.

The North Mississippi Medical Society met at University, Mississippi, October 5, 1932 and the following program was ably presented:

Chairman, Dr. John C. Culley, Oxford; Invocation, Malcolm Guess, Y. M. C. A. Secy., University; Address of Welcome, Chancellor Alfred Hume; Response, Dr. E. R. Nobles, Rosedale; Organ Solo, Selected, Miss Ruth McNeil, University; Vocal Solo, Selected, Mrs. Laura T. Martin, University; "The Cardiac Limitation of Advancing Years", Dr. James S. McLester, Birmingham, Ala.; "Acute Surgical Conditions of the Pelvis", Dr. J. W. Barksdale, Jackson; Lunceon at Cafeteria; "Shine Morgan Quartet"; Talks by: Dr. James M. Acker, President Mississippi Medical Association; Dr. Percy W. Toombs, President, Memphis and Shelby County Medical Society; Dr. P. W. Rowland, Ex-President Mississippi State Medical Association; "Changing the State Hospital System", Dr. J. Gould Gardner, Columbia.

The Women's Auxiliary Meeting was held at the Y. M. C. A. Building at 11:00 A. M. Address by Mrs. W. C. Pool, President Women's Auxiliary to the State Medical Association.

The North Mississippi Medical Society is made up of physicians from Benton, LaFayette, Marshall, Panola, Tippah, Union and Yalobusha Counties. Dr. H. P. Boswell of New Albany is president and Dr. A. H. Little of Oxford Secretary.

STATE BOARD OF HEALTH REPORTS WANTED

Dr. F. J. Underwood Secretary will be glad to get in touch with any one who may have the annual report of the State Board of Health for 1877 and also for the following Biennial reports 1882-1883; 1886-1887; 1890-1891; 1892-1893; 1894-1895. He feels that some of the older physicians might have some of these reports and he wants them for the Board of Health Library. If you have one write him at Jackson.

Community Hospitals and Their Relation to Medical Education

BY J. A. RAYBURN, M.D.
Pontotoc, Miss.

When we think of medical education, we usually think of it as it applies to the premedical subjects and of the four year graduate school, together with a certain number of interne months or years. Important as the preleminary training, and the school from which we graduate may be, it is small, when viewed from the standpoint of a lifetime of study. Every physician knows that if he is to be a successful practitioner of medicine that he must be a student throughout his career; and it must be understood that before study can become effective to any appreciable degree, that facilities and equipment must be provided, and a satisfactory system arranged, so that our efforts may be correlated and co-ordinated.

Medicine being a progressive science and an art, it is therefore necessary that it have some accessible means of keeping in close touch with medical progress; it is even more important to establish and maintain teaching facilities for practitioners than it is to graduate new practitioners. When one community has competent medical service and the other has not, the whole fabric of medicine suffers, and organized medicine has failed to fulfill its mission. Adequate medical service to all the people, at a cost within their means should be the goal of the medical profession. Medical service being of mutual interest both to the profession and the public, it is up to the profession through co-operative means to work out a plan whereby the whole of society will receive the benefits of a progressive science, which is in close co-operation with a refined art.

Hospitals, have come to be generally understood as laboratories for the treatment of the sick, and as training schools for physicians and nurses. The public appreciates the fact that while the sick can receive better treatment in a well equipped hospital, that the same facilities may be utilized for scientific teaching purposes, and in no way reflects on the character of service to the sick.

It was formerly thought that properly equipped hospitals could not be maintained except in the larger cities, and that competent physicians and surgeons could not be induced to locate in the smaller communities; recent advances however, in hospitalization and medical progress have shown these contentions to be erroneous. The medical profession and the public are beginning to realize that if hospitals are to serve their full purpose they must become accessible, and must be properly equipped and properly staffed.

Viewing the hospital situation in Mississippi, it will be seen that within the last few years splendidly equipped and splendidly managed small institutions have been established throughout the State, until they are beginning to be reasonably accessible to every community. These hospitals are supplying a real community need, and at the same time are enriching the medical profession in the knowledge of medical problems of state and community interest, but even so they have not reached that point of perfection, which can be easily attained, whereby they may exert a great influence toward co-operative teaching and medical education in Mississippi.

These small hospitals have given wonderful service, considering the fact that until recently they have operated as more or less isolated units living to themselves; making no effort to co-ordinate their powers. I think however, that there are a few members of the profession who are beginning to catch a vision of the possibilities of what may be accomplished through co-operative effort. It is not only the function of these hospitals to serve the sick in a competent manner, but to correlate and coordinate medical and surgical knowledge and see that it is properly disseminated.

Since the organization of the State Hospital Association, we are beginning to understand more fully the significance of the community hospital from a medical education standpoint, and to realize that through the medium of well regulated staff meetings we possess an unparalled system of post-graduate teaching, whereby the whole medical profession can participate.

Hitherto we have not understood the full meaning of community hospitals, nor appreciat- their significance as a pulsating dynamic force, in the progressive trend, of a progressive scientific art, but we are beginning to catch the halo of a vision, and appreciate the oft repeated proverb, that there is a silver lining behind every cloud. Community hospitals are the beacons which will bring us from darkness to light, and will emanate radiance, and beauty, and energy, and will cover the medical profession with everlasting glory.

In order for these institutions to serve a crying educational need as well as a practical scientific need, they must maintain contact with the profession, and be conducted in conformity with all well regulated teaching hospitals, giving the medical profession of their respective communities the benefits, and through them increased service to their clientele.

The organization of the State Hospital Association in co-operation with the State Medical Association, is a wonderful step forward. The appointment of a committee on community hospitals, and hospital legislation, shows the eagerness with which the profession is attacking this problem, but in order for the profession, and the community hospitals, to perform their functions with wholesome effect, they must be wary of political alliances and entanglements, and accept political favors with a degree of of skepticism, born of a desire for self preservation, and to circumvent the possibilities of State Medicine.

I think that the proper functioning of community hospitals, in control of the medical profession, under the leadership of the Medical and Hospital Associations, will greatly aid in solving the problem of state medicine, because such a system of practical and scientific medicine, will render adequate and efficient service to the commonwealth as a whole, at a cost within their means.

I have touched on the glowing possibilities of the community hospitals, as a medium through which the light of progressive medical education will shine, and cast its reflections on the whole of society; but in order that we may reap the full benefits of a well organized system, and add dignity and prestige and expanse, we must utilize every legitimate means at our command, to give us an educational background based on sound scientific principles, which will give us proper recognition from sources which are authorized to admit us into the sanctum sanctorum or holy of holies of scientific medical education.

It is a sad commentary on the medical profession of Mississippi, that we do not have within our borders an institution which is capable of giving an interneship approved by the American Medical Association, of which we are a part; yet we have an institution, which has a superabundance of clinical material, but lacks organization. I speak of the Insane Hospital at Jackson.

I have every reason to believe that with a well organized community hospital system built around the Insane Asylum, properly regulated and harmonized, we would have a pioneer system of medical education which would be fully recognized by the powers that be.

I do not think that it would require any great stretch of the imagination to see that if a medical and surgical unit was maintained in connection with the Insane Hospital, Mississippi could give an interneship unexcelled, and to utilize this institution for post-graduate instruction, as a nucleus around which community hospitals, may participate and receive the educational stimulus, so necessary to our professional life,, that we would have a system of practical medical education unsurpassed in any state.

Picture if you please, a well organized institution centrally located, with a capacity of 2500 patients plus, which could be utilized for scientific study and research, and which would work in co-operation, and be in affiliation with a well regulated system of smaller institutions, touching every community in the state, thus acting as a dynamic scientific force to enliven the whole, and give foundation for progressive thought.

Suppose that the medical profession had access to a well kept system of clinical records, based on sound scientific principles and clinical research, and had the sympathetic co-operation of a staff who understood and took pride in their work, and had a keen realization of the part they played in keeping the torch of medical education burning, so that the medical profession could work in co-operative unison. Suppose, if you can, the heights of prominence and worth to which we could climb if such a condition existed.

The medical profession, above all other professions, must be constantly engaged in the pursuit of knowledge, and in new fields to conquer, lest it become stale and somewhat ineffective. I do not mean that old means and and measures which have been proven must be thrown into the discard, but I do mean that we are constantly faced with new problems, and of necessity we must be on the alert for means with which to solve them; and this brings us into the van for the increasing necessity of constant progressive study, and the establishment of the necessary facilities whereby study may become effective to the whole.

We in Mississippi are aware of the problems of organized medicine, and of the increased demands being made upon organized medicine. We are aware also, that we are sorely in need of greater teaching facilities within the State so that the profession may have a readily accessible means of obtaining, constant scientific contact so necessary to our professional life and and well being.

We have the necessary machinery, which if properly organized and systematized, would set up a system of education which would be unparrelled and unsurpassed.

So that you may see the picture more clearly, I am appending a rough visual illustration of the far reaching effects of such an organization, and the dignity and charm it would lend to the medical profession of Mississippi.

The Acute Surgical Abdomen*

BY E. M. HOLDER, M.D.
Memphis, Tenn.

I count it a rare honor and a rare privilege to have the opportunity of appearing before the, the Royal family being present, Memphis and Shelby County Medical Society on this occasion.

When Dr. South was in the middle of his sermon, preaching at Westminster Abbey in London, the royal family being present, he was silent for a moment. Then he asked his congregation not to snore so loud, so that they might not awaken the Kind.

There are forty-six paragraphs, in my paper, the reading time of the paper being 22-32, unrelated as far as humanly possible, so that if you sleep through a few paragraphs the subject matter may be taken upon your awakening without loss. In fact, if you are suffering from a mild encephalitis lithargica you might sleep through the entire article without great loss, except to the ego of the ssayist, which doesn't count.

It is not desirable to attempt to discuss in this paper all of the lesions producing abdominal emergencies. Time will not permit. The textbooks of today cover the ground thoroughly.

The literature abounds in references to the appalling present death-rate. Something is wrong with our handling of the problem.

It has been a long belief of mine that more universal case co-operation between the physician and surgeon would, in a great way, minimize the death rate in abdominal emergencies.

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*Read before the North East Mississippi 13 County Medical Society, at Houston, June 20, 1932.

Outstanding and clearly cut signs and symptoms make the diagnosis of acute abdominal lesions comparatively easy in many cases. Others, however, tax the keenest minds, even when supported by all the diagnostic aids available to modern medicine. Fortunately, these "mystery" cases are not frequent.

It is estimated that more than ninety per cent of the cases of the so-called acute surgical abdomen are seen first by the internist. Consequently, it were better that a symposium on the acute abdomen be given, at this time, rather than a short paper on the surgical aspect only. Statistics show that acute appendicitis constitutes about seventy per cent of all such emergency attacks.

It has been said that the operative mortality in appendicitis has nearly doubled in America during the past few decades, and other emergency abdominal surgery is nearly as bad, while during this time in Britian it has been reduced fifty per cent. With the wealth of physiological work that bears directly on the subject, if used in time, and with State Medicine keenly alert for a foothold, we hope a "hint to the wise is sufficient." The death rate in acute abdominal emergencies is so appalling, and the economic loss so great, that if we do not arise to the occasion, State Medicine may relieve us of our burden as it has done in England and in many other foreign countries.

If the average physician could only know that his present troubles are really getting him somewhere, he would be content to endure and to strive, but it does not seem that we are getting anywhere. How can we improve our results?

The first step is the discovery of a new and better line of treatment than the methods hitherto employed, which have not produced results that may be regarded as satisfactory.

My hope in this discussion is to cultivate a finer perception of the meaning of the signs and symptoms of morbid conditions, that we may be enabled to arrive at an earlier diagnosis in abdominal emergencies, and to act more promptly.

I do not want to suggest that it is always possible to diagnose a case in a few hours, but I do assert that any case of severe abdominal pain which lasts for more than six hours is serious enough to merit the calling in of a consultant, not necessarily with the view to operating, but to clarify the problem.

There should be a time limit for the making of a diagnosis in a case of acute abdominal disease.

Upon the physician, who is the first to see the case, rests the greatest responsibility. He must recognize the urgency of the situation and determine the proper course to pursue. If he is lax or dilatory, the patient may experience irreparable damage, and may even lose his life.

Moynihan asserts "that there are no conditions which call upon the practitioner for skill and prompt action in the same degree, as do those acute emergencies which occur in connection with abdominal disease." As a matter of fact, acute catastrophies which occur in connection with abdominal diseases are in truth the acute terminations of chronic diseases, and are rarely acute new diseases.

The physician is confronted with two problems. First, is the lesion causing this emergency located within the abdomen, and second, if it is in the abdomen, is surgical interference warranted? His decision should be prompt. Correct treatment can rest only upon a correct diagnosis. A snap diagnosis may be impressive, but it is unsafe.

As abdominal emergencies, we think of acute appendicitis, cholecystitis, intestinal obstruction, ruptured peptic ulcer, rupture of a solid or hollow vicus, pancreatitis, mensenteric embolus, ruptured ectopic pregnancy, torsion of a cystic ovary, penetrating and non-penetrating abdominal traumers, and a host of other abdominal conditions.

First a short history of the attack is essential. Let the patient tell his own story; after he finishes, we may question him to obtain more details of what we consider the important points.

The physician should then proceed promptly with the physical examination. The first glance may suffice. The anxious, perspiring face may point to the shock of perforation or pancreatitis; or a death-like pallor with air hunger may be the evidence of a ruptured ectopic gestation.

In dealing with any acute surgical condition of the abdomen there are six diagnostic signs which are of paramount importance and a proper appreciation of which will often lead us to a correct diagnosis. These are: PAIN, VOMITING, TENDERNESS, PULSE CHANGES, TEMPERATURE CHANGES, and SPASM OR RIGIDITY. There are other signs such as facial expression, color of the skin, abdominal distention, etc., but these six are the most important in the early stages of the process; while the others may appear later and may be serious omens.

PAIN—is probably the most important and constant symptom of acute abdominal disease. It is usually an outstanding symptom of any acute surgical condition of the abdomen. Its onset is commonly very sudden; it may at first be slight, but as a rule soon becomes intense. By far the most common site of pain is in the region of the umbilicus with the onset of the disease; later it may localize over the region of the offending organ. It may be cramplike as is seen in the colics of renal, hepatic or intestinal origin, or it may be severe and constant as is seen in ruptured ulcers. While discussing pain it may not be amiss to recall that the patient with biliary or renal colic rolls and tosses about in his agony in contradistinction to the patient with the ruptured ulcer, who guards his whole body against the slightest movement.

This observation is not constant, however, for I recently operated upon a patient with an acute surgical abdomen, who presented the picture of a colic, but who had a ruptured duodenal ulcer.

In general the statement made by Cope that the persistence of abdominal pain for more than than six hours, in a person previously well, if accompanied by vomiting or a rising pulse rate or a rising temperature, indicates an acute surgical condition of the abdomen. If there still be doubt, we might better err on the side of safety and operate. Dr. C. H. Mayo, has said that he has never seen a patient die because of having an exploratory operation, but that he has seen many die because they did not have explorations.

VOMITING—is usually present in most of these conditions, too. It occurs shortly after the onset of pain. It may continue at intervals, or may cease after a short time. The abscence of vomiting must not be taken as an indication of safety, for we have all seen patients with a gangrenous appendix who did not vomit.

TENDERNESS—is an important sign usually found in the acute surgical conditions of the abdomen. It may be superficial or deep. Superficial tenderness is really a cutaneous hyperesthesia. It may be elicited by pincing or rubbing the skin. This is a reflex phenomenon. Superficial tenderness has some diagnostic value, but it is not always dependable. Deep tenderness is of much more value. It is commonly found directly over the organ involved. At first it may be more generalized, but as the disease localizes, it becomes more circuscribed. The so-called rebound tenderness, is elicited by sudden release of pressure over the tender area. It probably has no more significance than deep tenderness.

PULSE CHANGES—The rate and volume of the pulse remained apparently normal in rate and volume, these are in the minority. Still a so-called normal pulse should not alter one's judgment of a serious condition. The pulse rate commonly rises with the progress of the disease, and for that reason, frequent takings of the pulse are often of value, whereas a single recording is valueless. A pulse rate higher in proportion than the temperature means progressing infection with low resistance and is a bad prognostic sign.

TEMPERATURE CHANGES—for the first few hours after the onset of the disease, there will probably be little or no change in the temperature. Then there will be an elevation to 99 or a 100. Temperatures higher than this mean spreading infection and are rarely seen in the acute surgical conditions of the abdomen until late. A subnormal temperature, in the face of an obviously severe abdominal condition, is indicative of shock in the early stages; later it is evidence of lack of resistance. It should be remembered that many acute conditions are afebrile until late or even throughout their entire course, while occasionally—particularly in children—a temperature of 103 degrees Fahrenheit or more may be found early in appendicitis. It is unwise and sometimes fatal to wait for the appearance of fever in a case of suspected abdominal lesion.

SPASM AND RIGIDITY—are usually encountered in acute surgical conditions of the abdomen. They are part of the defense mechanism of nature and are true objective signs. In the very early stages they may be absent or slight, but they soon appear in the area overlying the affected organ. If the process becomes more generalized, then spasm and rigidity increase and vice versa. Spasm and rigidity will vary with the nature and location of the process. The almost board-like rigidity seen with the ruptured ulcer case differs markedly from the slight spasm seen with the mild appendix case. The retrocecal appendix though badly diseased, may give rise to but little spasm and rigidity. Rigidity is marked in perforation, but may be slight or absent in abdominal hemorrhage. Rigidity without tenderness strongly suggest that the pathological process is not in that particular region. It should make us look carefully to other parts, particularly the chest.

LESIONS OUTSIDE THE ABDOMEN—Lesions outside the abdomen which may simulate the acute abdomen are chiefly in two groups—pulmonary and cardiac. Pain of a diaphragmatic pleurisy or of a pneumonia near the diphragm may be referred to the abdomen and muscular rigidity may be present. But there is no tenderness, however, unless the lesion be close to the diaphragm, and usually there are distinctive changes in the rate and character of the respiration, and in the physical signs in the chest. How frequently this error occurs can readily be seen from the report of Adams and Berger, that twenty-five patients of one hundred and forty-five suffering from lobar pneumonia were sent to the Boston City Hospital with a diagnosis of appendicitis.

The physical findings in the chest should clear up the matter. Pressure over the site of referred pain in the abdomen relieves the discomfort, whereas it increases that of acute abdominal disturbance.

In pericarditis much the same picture may be present, except that respiratory changes are usually slight or absent. In coronary thrombosis, or in true angina, the pain may be referred to the abdomen, causing epigastric distress, shock and vomiting, as typical an acute abdomen as one could imagine, but again there is no tenderness.

Pain in the abdomen with nausea and vomiting may be evidence of a gastric crisis in tabes dorsalis. A careful examination should establish or disapprove its identity without much trouble. An examination of the eyes and tendon reflexes should clear up the point.

Another group of cases may be confused with acute abdominal emergencies; namely—lesions of the urinary tract. Pain and regidity may be present and even slight tenderness along a ureter, if it be involved. Tenderness usually is found over one or the other kidney, pain is referred to the groin, there is frequently a tender spot at the symphysis on the corresponding side, and nearly always there are significant urinary findings.

Cork reports twenty per cent of his urinary cases having previously had appendectomies without relief of symptoms. This means twenty per cent of diagnostic mistakes.

Of course, we recognize that many kidney conditions may mimic abdominal crises, but they are not often abdominal emergencies. We know that but few acute gall bladders require immediate surgery, and the general opinion today seems to be that acute inflammatory disease of the pelvis also should not be operated upon in the active stage, unless drainage of a large abscess be required. These are common exceptions to the rule. By constantly keeping these exceptions in mind, we will be much less likely to allow serious and often fatal delays to occur.

INJURIES TO THE ABDOMEN—Injuries to the abdomen may result in conditions requiring immediate surgical attention, so it is proper that we consider them in discussing the acute surgical abdomen.

Moynihan, the peer of English surgeons, makes this statement: "Any surgeon whose experience in hospital work is extensive will have realized the great difficulty that almost always exists in discriminating in the early stages between those cases of abdominal injury which are trivial and those in which laceration of the intestine has occurred." In general, Cope's law may be applied, that the persistence of abdominal pain for more than six hours after injury, if accompanied by vomiting or a rising pulse, or increasing rigidity, is an indication for exploration. A severe abdominal injury is accompanied by all the signs and symptoms of an abdominal catastrophe, but an immediate operation during shock in abdominal injuries is not to be thought of except in a case of perforation or for the purpose of arresting bleeding.

The patient complains of severe pain. Vomiting usually occurs promptly and is persistent. Shock of variable degrees may prevail. Tenderness is marked over the damaged organ. Spasm and rigidity appear with peritoneal involvement. The pulse is usually rapid and feeble; and the temperature remains normal or subnormal until infection occurs, or reaction takes place.

Injuries to the pancreas, liver, spleen, or intestines must be kept constantly in mind when dealing with abdominal injuries, for prompt action here again is imperative. Injuries of the bladder are also serious and demand early recognition and prompt treatment. The test of injecting a measured quantity of sterile water into the bladder through a catheter and then aspirating is quite reliable. If we get all the water back, the chances are that the bladder is whole; if not, we suspect rupture. It is to be kept in mind that rupture of the bladder is accompanied by considerable shock as a rule.

We need spend no time discussing the penetrating type of abdominal wounds for these so obviousl require immediate surgery that no indecision remains in the mind of the physician.

With his prompt recognition of the fact that an acute abdominal lesion is present, excluding the renal cases, the acute inflammatory pelvis and the acute gall bladder, there is but one course for the physician to pursue: prompt surgical interference.

If he is in doubt as to the exact nature of the intra-abdominal lesion, and the question were asked—what is the matter? To this, I have always given my second best answer to any question, "I do not know." But an exploratory operation should be done. Delay nowadays in obtaining surgical care is absolutely inexcusable.

The physician who suspects that his patient may have appendicitis or any other acute abdominal emergency, should see him again in not more than six hours. To do otherwise is gross neglect. Meanwhile that patient should be kept as quiet as possible, with absolutely no food, no cathartic, no enema, and no opiate.

A leucocyte count should be done and the urine examined as soon as possible. There can be little excuse for neglecting these two, and there is no excuse for the physician who plans his next visit on the morrow.

Fagge, writing in the British Medical Journal, January 10, 1931, states that one-third of the abdominal emergencies are obvious, one-third doubtful, and one-third impossible of diagnosis. If we are going to save the impossible and doubtful cases, operation must be done early.

It is just cause for sadness that the rising mortality in the acute abdominal cases, is due not alone to mistakes in diagnosis, but to neglect upon the part of the medical attendants.

Mistakes occur, of course. It is possible that there may be, for generations, a small irreducible minimum of mortality in appendicitis, and other abdominal emergencies, but that excuse has the physician who makes a definite diagnosis of a serious surgical lesion and then neglect to offer the proper remedy?

One is reminded of the late lamented Dr. Deaver's statement that "in perforation, early operation by a mediocre surgeon is better than a too-late operation by a master." And "better, a needless operation than a needless death."

To summarize, we may say: the part of the internist is to recognize at once that an acute abdomen is present in the patient and that prompt surgical care is imperative. When such a part is played by the men first seeing the cases, our mortality in the acute surgical abdomen will subside remarkably. Its present height has been due to causes which have been aptly epitemized by Dr. John J. Morton of the University of Rochester—"laxity and laxatives."

"For our blunders, O, in shame before the eyes of Heaven we fall."

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Pulmonary Hemorrhage In Tuberculosis with Special Reference to Treatment

BY DR. W. A. TOOMER
Tupelo, Miss.

When we consider that pulmonary tuberculosis is a disease affecting the parenchyma of the lung, which is a veritable network of blood vessels, it seems strange that any patient suffering from this destructive disease could escape hemorrhage. That they do is owing to the fact that while tuberculosis is a chronic inflammation accompanied by necrosis, with an inflammatory process usually preceding the necrosis. The blood vessels take part in the inflammation; their walls thicken, a thrombosis forms, obliterating the lumen, and bleeding is forestalled before the vessels are affected by the necrotic process. The frequency of this complication depends a great deal on the character of the patients observed, being less common in early cases and more frequent in advanced ones. Some degree of bleeding is probably found in three fourths of all cases at some time during the course of the disease.

Cause of Hemorrhage: It is usually believed that hemorrhage is due to over exertion; but, in my experience the greatest number of hemorrhages have come on while the patients were lying in bed, even some of the fatal hemorrhages have appeared in the middle of the night, the patient expiring within a few minutes. At times hemorrhages follow over-exertion, such as lifting weights, running for a car, climbing hills or other strenuous physical exercise. While exertion may be the determining cause, the real cause of the hemorrhage is the pathological condition affecting the vessel walls. If an aneurism, or an ulceration of the vessel wall is present, a rupture may occur at any time. Most hemorrhages that come on following exertion probably would have been delayed for a time had the patient avoided exertion, but they probably would have come on later just the same.

Types of Hemorrhages—The majority of hemorrhages are small and the patient expectorates a mouth full of blood occasionally, sometimes this condition continues for several days. In this type of hemorrhage there is usually an erosion in the blood vessel wall, how-

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ever, blood streaked sputum is at times the forerunner of a very large hemorrhage. In this type of case the blood is coming from a necrotic area which is about ready to slough and when the separation occurs a large blood vessel is opened.

Severe hemorrhages may be due to either a rupture of an aneurism or an erosion of a vessel; the former is by far the more common. From eighty postmortems following fatal hemorrhage, in one institution, ruptured aneurism was found in seventy. The cause of aneurism is the weakening of the vessel wall either because of the lack of suppor tor because of an extention of the tuberculosis inflammation. Another type of hemorrhage is that where the blood comes from very tiny vessels in a cavity. The walls of the cavity are sometimes lined with delicate vessels, so delicate that even the removal of sputum or coughing will rupture them. This type of bleeding is usually recognized by the fact that the blood is thoroughly mixed with pus coming from the cavity. This usually means new tissue formation in a cavity and is favorable to healing.

Treatment of Hemorrhage—First of all, we should know the condition of the patient's lungs, the extent of the pathology and the location of the cavity if one be present. There should be a record of the chest examination, also sterio plates when possible to have them. When a cavity is present we know that the hemorrhage is coming from this area in a great majority of the cases. Sometimes it is very difficult to determine from which lung the hemorrhage is coming especially in cases where you have no records of a previous examination or an X-ray plate. Severe hemorrhages are very distressing to the patient and the family, and the first step in the treatment is to reconcile the patients and the attendants. The patient should be made comfortable and put on absolute rest as soon as possible; should be placed on his back and in the majority of cases. The head of the bed should be elevated except in cases where the hemorrhage has veen extremely large and the volume of blood is diminished to such an extent that it is necessary to have the head lower than the body. In order to quiet the patient I usually administer one-eighth grain of morphine hypodermically but never give this drug in large doses to these patients. Absolute physical and mental rest is of the greatest importance. If the bleeding is severe no movement should be permitted. The patient should not be permitted to raise his head or use his hands and should not be allowed to move his body until all active bleeding has ceased. The patient should be kept quiet until after clots of all kind have been absent for two or three days and then his position may be changed by the nurse, but he should not be allowed to make any exertion himself. These regulations may seem somewhat stringent but no precaution should be omitted which will tend to prevent recurrence of bleeding. Patient

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should not be allowed to talk except in a whisper and visitors should be excluded. The only examination permissible is that made by inspection, palpation and auscultation without moving the patient. Percussion should not be practiced.

The diet depends largely upon the severity of the hemorrhage. In frank hemorrhage, efforts at swallowing increase the bleeding. In slight hemorrhage, efforts at swallowing increase the bleeding. In slight hemorrhage, characterized by blood streaked sputum, efforts at swallowing have little or no influence. In severe hemorrhage all foods and liquids should be withheld for a time excepting small quantities of cracked ice.

Drugs play a minor part, though if judiciously used, an important part in the therapy of hemoptysis. To quiet the excessive cough is the indication for a sedative, preferably codeine given hypodermiclly. This drug should be given in small doses and repeated as necessary to control cough. If the blood pressure has not been lowered sufficiently by the loss of blood it may be further reduced by the use of nitroglycerine or sodiumnitrite—I prefer the former. Morphine should not be used except to relieve the nervousness of the patient, usually an initial dose is all that is required. I never give purgative until the end of forty-eight hours following th hemorrhage, but if good results can be had from an enema the laxative is not required. Artificial pneumothorax is a most valuable measure in persisting or recurring hemorrhages which fail to respond to other methods of treatment. In severe cases where the bleeding is profuse and we are sure from which lung the blood is coming an immediate collapse will control the hemorrhage, but in a great many cases pleural adhesions or a dense fibrosis of the cavity wall will prevent the proper collapse. The transfusion of blood is indicated when the blood loss is severe. Drugs which are supposed to increase the coagulability of the blood have been used for a long time but are of doubtful value.

Absolute rest is more valuable than all other remedies combined in the treatment of pulmonary hemorrhage. Codeine to control the cough and artificial pheumothorax in suitable cases are of considerable value.

The greatest service which the physician can render in cases of ordinary hemorrhage is to take a seat by the patient's bed and quiet his fear and assure him that he is going to be all right. A great deal of harm is often done by too much medication and treatment.

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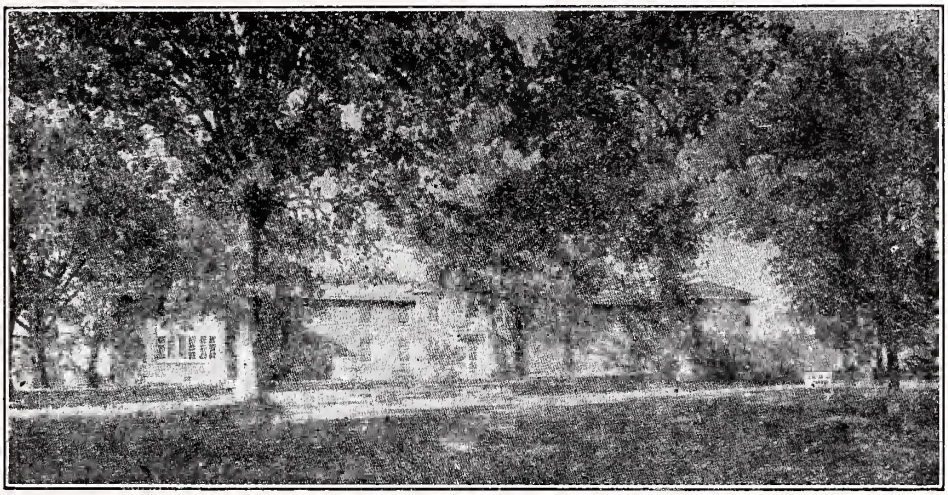

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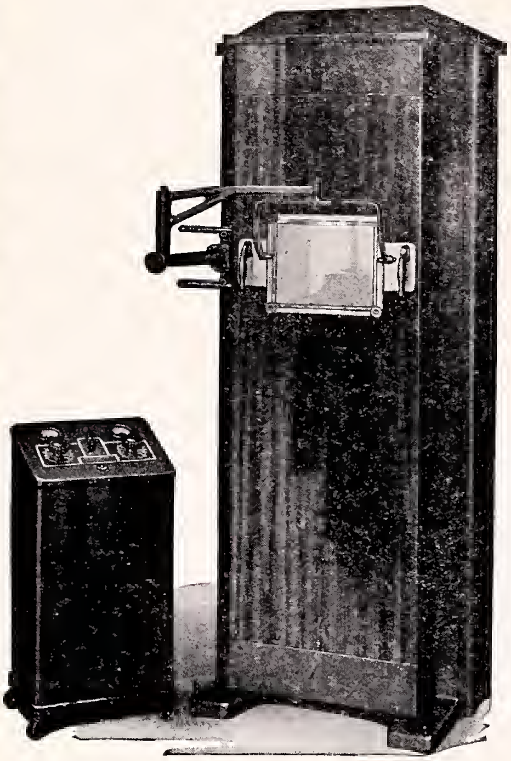

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Just a few short years ago, there was much said about the shortage in the medical profession, but now we are more concerned with the surplus. It hasn't been any time since short cuts were advocated by our ablest men in the profession in order for us to have more physicians in practice, especially in the country. But we really have an over supply. We have about one to every seven hundred population. England has about eleven hundred perhaps as an average. We have never believed in the short cuts to increase the number of physicians. The income of physicians must be increased. The facilities he now has at his command he can do so much more work than he could two or three decades ago. The medical profession has destroyed much of its income, much of its work, by exterminating or controlling disease. There are multiplied reasons why the physician can take care of a greater number of patients than he formerly could. The medical schools should reduce the number entering the profession, we believe. The schools should have a different system of selecting the candidate for a medical degree. He should be physically fitted for the job and he should a professional mind, a medical soul and a missionary heart. Preventive medicine and preventive surgery should be taught in a more practical form. Prevntive medicine cannot be done by the county health officers. The entire profession must enter into it and do his part and he must be paid for this type of service. The laity must be further educated. This can best be done through the lay press, and especially through the country weekly.

The surgeons of Memphis are invited anywhere over the tri-states to operate. They are treated nice and their services are appreciated, but the Baptist and Methodist Hospitals of that city have a shut out policy that does not allow a surgeon outside of its limits to operate within their walls. This is as much to say that safe surgical knowledge is confined to the city limits or else it is a very selfish policy. It is not in keeping with the trend of modern medicine today. Again we say that consistency is a rare metal even in the medical profession.

In 1931 forty one thousand dollars was paid out for salaries at our five state charity hospitals. The interest on the investment would easily amount to thirty thousand and the upkeep for all of them another thirty thousand, or in other words they cost the state a hundred thousand dollars before they treat a patient. No legislator can justify their existence at this time, no honest business man would think of doing it.

The medical profession is prone to hobbies, the country doctor has his farm, and the would-be specialist, struts his Poker.

How about the finance corporation furnishing the medical profession with some practice that it can afford to cultivate.

A constant abdominal pain that lasts more than an hour had better be counted appendicitis until it can be proved otherwise.

But few mothers furnish as much milk as the baby needs. One or two feedings of cow's milk each day is usually very beneficial.

The twenty counties in the North East corner of the state should have a hospital organization to take concerted action on our hospital bill.

Group insurance is a nice arrangement for the medical profession. It activates the fraternal spirit. It saves you much on premiums.

The "depression" is beginning to show on the health of the nation and it is also weighing mighty heavily on the social and economical status of the profession.

Everything else being equal you should buy your office supplies from the man who advertises in The Mississippi Doctor, that is if you have any interest in your journal.

Dr. McGahey is giving us a good paper on pneumonia. It is one disease in which the treatment of the patient is the most essential consideration. Rest is one of the big items.

Dr. Felix J. Underwood, our well known and efficient Secretary of the Board of Health has been mentioned for the post of Surgeon General. He could do the job in fine style, no doubt about this.

You will enjoy S. K. Gore's paper on Diabetes and the discussions. We are sorry Dr. Bowen's discussions did not reach us in time to go in. A more balanced and sensible diet is the order now in the treatment of this disease.

Dean Mull of the Ole Miss Medical School believes in quality rather than numbers. His school could be running over with the left overs and "fureners," but Dr. Mull did not consent. He is guarding the quality and holding up the high standard of the past. He is right. As long as we have Dean Mull you need fear no evil of our medical school.

From Here and There

Dr. and Mrs. R. D. Kirk, of Tupelo, are being congratulated upon the arrival of a new son, Albert Murphy, who made his advent Nov. 7.

Dr. S. L. Pharr, of Booneville, is recovering from an operation for appendicitis.

Dr. Hayden Sutherland, who has recently taken up his practice with his father in Booneville, was married last month to Miss Vivian Hollandsworth, a talented and attractive young woman whose home was in Jacinto.

A goodly number of the doctors of this section enrolled for the lecture course conducted by Dr. McCord in Booneville last month.

The following announcements of several of the Memphis doctors is of interest to our section: Drs. J. W. Bodley, John M. Maury, Sr., and John M. Maury, Jr., announce the removal of their offices to the Polyclinic 20 South Dunlap Street.

Dr. Thomas Moore is located at 1052 Madison Avenue, suite 2 and 3, since the removal of his offices from the Polyclinic.

Eight members were added to the American College of Surgeons from Mississippi at its recent meeting as follows: Dr. Clyde J. Lewis, assistant sup't Mattie Hersee hospital; Dr. H. Lowry Rush, surgeon at Rush's infirmary; Dr. K. T. Klein, surgeon in charge at Meridian Sanatarium; Drs. John K. Birchett, Jr., Vicksburg, George Frank Carroll, Biloxi, Richard J. Field, Centerville and George M. Street, Vicksburg.

Dr. Hugh Clemmer, formerly of Ripley, was married recently to Miss Pauline Merritt and left for North Carolina.

Dr. John Tate is associated with Marsh's Clinic in Ripley.

Dr. Joe Kellum has recently located in Baldwyn where he will practice.

Dr. Bob Christian has gone to North Carolina where he is employed with the Veteran's Hospital.

Dr. Ralph Bowen, Pediatrician, formerly of the Polyclinic and Memphis, is now associated with Dr. Ray M. Balyeat of Oklahoma City in his Hay Fever and Asthma Clinic. He is giving his full time to the management of allergic problems seen in children. Dr. Bowen will be missed by the profession of our territory as a consultant in pediatrics. He will be missed in our meetings. But our good wishes go with him in his new field. He has a standing invitation to visit our society any time, as does Dr. Balyeat, who sold himself to us a hundred percent his first visit.

Dr. Turner Googe who served so efficiently as county health officer of Lauderdale is taking post work in Harvard. His family went along with him and he will be up there for several months. Dr. Googe is one of the outstanding men in public health work in our state. We will hear more of him as time goes on.

Dr. R. L. Sanders of Memphis now has his offices in the Physicians and Surgeons Annex of the Baptist Hospital.

The North East Mississippi Hospital are having regular staff meetings now with Dr. L. L. McDougal as president and Dr. R. B. Cunningham as Secretary.

General News

Dr. James R. McCord, Professor of Obstetrics and Gynecology of Emory University Medical School, will conduct a course of lectures at Clarksdale during the week beginning December 5. Dr. V. B. Harrison, health officer and secretary of the Clarksdale-Six Counties Medical Society, is in charge of arrangements. Physicians from that section of the State are urged to attend.

* * *

The regular meeting of the Mississippi State Board of Health will be held in the office of the executive officer, Old Capitol, on December 12, at 7 P. M.

* * *

More physicians in Mississippi are filing birth records promptly this year than ever before. Undertakers are filing death records according to the regulations, except in occasional instances.

* * *

The following attended the meeting of the American Public Health Association in Washington: Dr. J. A. Milne, Dr. T. Paul Haney, Jr., Dr. T. W. Kemmerer, Dr. Felix J. Underwood, and Mr. H. A. Kroeze. Drs. Haney and Milne were given the trip by the Commonwealth Fund and they went several days in advance in order to attend the institute on health education held prior to the American Public Health Association meeting.

* * *

The annual Conference of Health Workers will be held in Jackson on December 12, 13, and 14. Dr. Allen Freeman, Professor of Public Health Administration, Johns Hopkins University, will give two lectures each day. Other speakers will be Dr. G. A. Wheeler, of the U. S. Public Health Service; Dr. L. M. Graves, Health Commissioner, Memphis; and Dr. J. D. Dowling, Director of the Jefferson County, Alabama, Health Department, Birmingham. All county health officers and sanitary inspectors are expected to be in attendance at this conference and any physicians who are interested in attending are cordially invited to do so.

GUY HAINES WOOLLETT, B.S., M.S., Ph.D.

Professor of Physiological Chemistry

Born in Minneapolis, Minnesota, Dr. Woollett received three degrees from the university of that state. In 1910 and 1916 he earned his B. S. and M. S. respectively. The latter year he came to the University of Mississippi as assistant professor of Chemistry (Organic and Physiological), and returned to the University of Minnesota in 1918 to complete fulfillment of the requirements for his Ph.D. From that year until 1920, he was Instructor in Organic Chemistry in that institution. He then returned to Mississippi to act as Associate Professor of Chemistry (Organic and Physiological) for six years. At the expiration of that time, he was elected to the Professorship of Physiological Chemistry. He was Head of the Department of Chemistry of the University of Mississippi 1930-32.

The above likeness of Dr. Woollett shows him in his working clothes—he is happiest when he is busiest. He is imbued with a true scientific spirit; consequently, problems of research mean much to him. At the present time, he is working on the following: (1) Preparation and Decomposition of New Polyiodophenols. (2) Effect of Iodophenols upon Basal Metabolism. (3) Metabolic Fate of Alpha Amino Isobutyric Acid.

Included in his publications are: (1) The Salts of Tri-iodophenol and their Catalytic Decomposition. J.A.C S. 38, 2474, 1916. (2) The Decomposition of the Silver Salts of Tri-chloro and Tri-bromophenols. J. A. C. S.—43, 135, 1931. (3) The Action of Mercury on Tri-bromophenol bromide. J. A. C. S.—43, 131, 1921. (4) Aristol (an investigation of its chemical structure and the cause of its antiseptic action). J. A. C. S.—43, 553, 1921. (5) Di-iodothymol and the Decomposition of its Salts. J.A.C.S.—52, 4018, 1930.

Dr. Woollett is a member of the American Chemical Society and the Association for the Advancement of Science. He is also affiliated with Sigma Pi fraternity. Mathematics is one of his favorite subjects, and the deeper and more involved problems are, the better he likes them.

The first-year medical students at Ole Miss spend considerable time learning "P. Chem." There is much to be known about that subject, including pH, amino acids, various theories, etcetera, and Dr. Woollett insists that "what should be must be."

To Each County Health Officer

Dear Doctor:

The Annual Health Officers' Conference will be held December 12, 13, and 14, Robert E. Lee Hotel, Jackson.

Dr. Allen Freeman, Professor of Public Health Administration, Johns Hopkins School of Hygiene and Public Health, will be with us for all three days and will give two lectures each day.

Drs. Mountin and Wheeler of the U. S. Public Health Service will be here. Dr. Mountin will talk to the conference twice—once on rural sanitation and once on the value of records of health work accomplished. Dr. Wheeler will talk about pellagra.

Dr. L. M. Graves, Director of the Memphis Health Department, and Dr. J. D. Dowling, Director of the Jefferson County (Alabama) Health Department, have both accepted places on the program.

We expect Dr. C. W. Stiles to be with us for the conference.

One means of furthering the work of public health is the earnest discussion of common problems which present themselves in the course of the work. This annual meeting will afford an opportunity for such discussion.

A program will be sent to you later. Make your arrangements to be with us. All sanitary inspectors should attend.

With best wishes, I am

Very truly yours,
FELIX J. UNDERWOOD, M.D.

Announcement

Dr. W. H. Anderson, Editor,
Booneville, Miss.

My dear Doctor Anderson:

At its meeting of October 8th, the Board of Directors of the American Society for the Control of Cancer took the following action:

"It was voted that the Bulletin of the Society be made its official organ and that the present relationship between the Society and the American Journal of Cancer be discontinued."

If you feel inclined to give this piece of information space in your column of news, the Society would greatly appreciate it.

Very truly yours,
C. C. LITTLE,
Managing Director.
25 West 43rd St., N. Y., N. Y.

A Resolution

To the Secretaries of the County Medical Societies:

The following resolution was passed by the Fulton County and Cobb County (Georgia) Medical Societies at their regular meetings a few weeks ago after the reading of a paper entitled "The Economic Status of the Medical Profession," which appeared later in the Journal of the American Medical Association, October 15, 1932, Page 1358, under the Department of Medical Economics.

Since this article appeared, we have had numerous letters from physicians all over the United States urging that this plan be placed before the different county, state and national societies for their consideration and adoption.

We are asking that you place this or a similar resolution before your society and ask for its adoption. Have it signed by your proper officials and forward to the secretary of the Medical Association of your state.

These resolutions will be placed in the hands of the delegates to the American Medical Association at its next annual meeting.

RESOLUTION

Whereas, the medical profession of the United States is suffering losses all out of proportion to its ability to endure, and

Whereas, our losses are not so much due to the financial depression as to over production of doctors and decreased demand for paid medical service generally, and

Whereas, the production of doctors is far in excess of the population increase,

Therefore, we the members of the ______________________________ County Medical Society respectfully request the Medical Association of ____________________, the other State Medical Associations, the Southern Medical Association and the American Medical Association to adopt this or similar resolutions requesting the Medical Colleges of the United States to reduce the number of graduates each year until the law of supply and demand has been fully complied with. The number of graduates to be determined by a national committee appointed by the President of the American Medical Association.

Respectfully submitted,

______________________________M.D., President
______________________________M.D., Secretary

Pneumonia*

BY F. L. McGAHEY, M.D.
Calhoun City, Miss.

In presenting these few remarks on pneumonia I do so with a full realization of the fact that this is one of the most important diseases with which the medical profession comes in contact and one that, if properly presented, would require considerable time and would also require an abler man than I am.

Pneumonia is an acute infectious disease characterized by an exudative inflammation of the lungs, involving either a lobe or an entire lung, in which case it is termed lobar pneumonia or it may involve the bronchioles and smaller bronchi in which case it is termed broncho-pneumonia.

Etiology—The pneumococcus is the exciting cause of lobar pneumonia and may be the exciting cause of some cases of primary broncho-pneumonia. The streptococcus, staphylococcus, influenza bacillus, tubercle bacillus and diphtheria bacillus may also be the exciting cause of broncho-pneumonia, however in practically all cases the infection is mixed.

The predisposition to pneumonia seems to be greatest during the first three or four years of life, then gradually decreases to about the eighteenth year of life, then a slight increase with each decade of life. In children, both sexes are about equally affected, but in adults males are more often affected than females. Broncho-pneumonia may occur secondary to bronchitis, measles, pertussus, scarlet fever, influenza, diphtheria or any of the acute infectious diseases. Any disease or condition that has a debilitating effect on an individual will render him more susceptible to pneumonia and alcoholism is probably the most frequent predisposing factor in this class of cases. Climate does not seem to have any predisposing influence, as pneumonia occurs about equally in hot and cold climates, however statistics show that by far the most cases occur in the Winter and Spring months.

Pathology—The pathology of lobar pneumonia may be divided into three stages, congestion, consolidation and resolution. During the stage of congestion the capillaries and vesicles are filled with a serous fluid containing endothelial and red blood cells. This stage usually lasts only a few hours and passes into the stage of consolidation at which time the exudate undergoes coagulation necrosis and the air vesicles contain a varying amount of fibrin in addition to the endothelial and red blood cells. At this time the lung is solid will sink in water and is dark red in color. Then the color begins to change to gray which is due to an absorption of the red blood cells. The lung tissue is also anemic due to pressure of the exudate on the blood vessels. The cut surface has somewhat the appearance of broken granite. This is followed in a few days by the stage of resolution during which time the exudate undergoes degeneration and liquefaction and is partly expectorated and partly absorbed after which the lung regains its normal color. In broncho-pneumonia the lung contains scattered areas of consolidation corresponding to the individual lobules which are usually pale in color and surrounded by congested lung tissue. The cut surface is smooth and moist and on pressure a frothy serum exudes from the healthy portion and a grayish yellow fluid from the diseased areas. Sometimes a number of these small areas of consolidation coalesce and involve an entire lobe in which it is impossible to differentiate from lobar pneumonia by the physical findings.

Symptoms—Pneumonia is usually ushered in with a chill which lasts from one to two hours and gradually subsides. Soon the skin and mucous membranes become flushed and red and vomiting and delirium may appear with an elevation of temperature to as high as 104 or 105. There is usually a sharp cutting thoracic pain, most severe when patient coughs, sneezes or breathes deep. The respirations are rapid, superficial and sometimes irregular with an expiratory grunt and dilitation of the nostrils with each respiration. About the third day herpes appear on the lips, the thoracic pain diminishes in intensity and the cough becomes productive, giving us the characteristic tenacious prune juice sputum. The temperature and tachycardia remain unchanged for several days and there may be a suppression of breath sounds over the area involved or there may be tubular breathing.

These symptoms continue for several days and may become more marked with weaker and faster pulse and increased cyanosis and consolidation at which time resolution may begin, followed by the crisis in most cases or less often by a gradual improvement in all symptoms or lysis. At this time the temperature either falls suddenly or gradually, the body is usually bathed in a profuse, cold, perspiration. The respiratory efforts are easier, slower and less labored, the color improves and the patient's general condition improves rapidly.

In the more severe cases resolution is delayed or does not occur, the dyspnoea and cyanosis increase, the temperature remains high, pulse becomes weaker and faster, patient becomes restless and delirious and finally passes into a state of collapse.

Diagnosis—The diagnosis of typical cases of pneumonia is not often difficult. Given a patient with history of a sudden onset, with a chill or rigor, high fever, rapid shallow respiration accompanied by an expiratory grunt, thoracic pain, presence of a cough, thick tenacious rusty sputum, tachycardia, presence of herpes on lips anda leukocytosis with physical signs of pulmonary consolidation, we do not hesitate to make a diagnosis of pneumonia. I have never made any special efforts to nor do I think it necessary to differentiate between the various types of pneumonia unless we are prepared to type the exciting pneumococcus. If we are able to assure ourselves that the patient has pneumonia, regardless of whether it is lobar, broncho or any of the various types of either, I think we have done well and should begin at once to treat the patient and not the pneumonia. In making a differential diagnosis the most important things to be excluded are pleural effusions, acute pulmonary tuberculosis, pulmonary abscess, typhoid in early stage and acute abdominal diseases such as appendicitis, perforated gastric or duodenal ulcer, cholecystitis and pancreatitis. None of these conditions should be very difficult to differentiate from pneumonia after making a very careful complete physical examination, including laboratory and X-ray findings.

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*Read before June meeting of the N. E. Miss. Medical Society at Houston.

The use of a syringe and a suitable needle for thoracic tapping is all that is necessary to differentiate a pleural effusion. In case of an acute pulmonary tuberculosis, the history of the case, constitutional symptoms less marked, sputum less viscid and more purulent and presence of tubercle bacilli serve to make the differentiation. In case of pulmonary abscess we have sweats, chills, anemia, great prostration, high leukocyte count and may also resort to paracentesis and X-ray examination to make the differentiation. Acute abdominal diseases may be differentiated from pneumonia by a careful examination of the thorax, laboratory examination and X-ray findings. Meningitis is sometimes confused with pneumonia, especially in children, and in addition to usual examination, it is wise to make an examination of the spinal fluid to complete the differentiation.

Prognosis—Pneumonia is always a serious disease and the prognosis should always be guarded. The death rate is especially high in infancy and early childhood, somewhat lower between ages of five and sixteen. The maximum death rates are at the extremes of life. The death rate is somewhat lower in those who have had one or more previous attacks. The prognosis should be especially guarded in individuals who have chronic valvular heart disease, nephritis, arteriosclerosis, diabetes, malignant disease and in alcoholics. In cases where we have an abrupt fall in blood pressure, with tachycardia or a respiratory rate of over fifty in adults with marked toxic manifestations or a persistent abdominal distention, the prognosis is most unfavorable.

Treatment—The essential point is to always treat the patient and not the disease. Proper ventilation is of more importance in the treatment of pneumonia that in any disease or condition I know. The room temperature should be kept around 65 degrees F, with windows open but patient protected from draughts. Light woolen under clothing should be worn and bed covering should not be too heavy. Patient should not be allowed out of bed but should be kept quiet and not overburdened with excessive attention. At the onset, the bowels should be opened freely, preferably with calomel and oil and kept open afterwards with enemata, salines, milk of magnesia, cascara or any good laxative. The mouth and nose should be kept clean with some good antiseptic solution. The patient should not be fed oftener than every three hours and only liquids or semi-liquid foods should be given during the febrile stage. A diet of milk, beef juice, scraped meat, broths, gelatin and well cooked gruels of rice, barley, wheat or oatmeal with an abundance of water is usually satisfactory.

For the thoracic pain an ice bag may be applied or light mustard poultice and hypodermic of codeine given and in case these do not give relief I strap the side with adhesive and give a moderate dose of morphine hypodermically. Morphine should be used very cautiously or possibly not at all in the aged and in those who have chronic kidney lesions.

Codeine or some preparation containing codeine is the best to use for cough.

In cases where the temperature is high and patient is restless or delirious with rapid pulse, dyspnoea and cyanosis an ice bag to the head and cool sponging or a cold pack extending from the clavicle to the umbilicus and changed every hour usually affords considerable relief.

I am of the opinion that every case of pneumonia requires stimulation at some time during the course of the disease and that we have no better drug to rely on than digitalis. I believe in and practice early digitalization. In case of an emergency, camphor in oil, digitalin or caffeine sodio-benzoate given hypodermically are the best drugs we have at our command.

Alkalies with an abundance of water are rcommended to combat acidosis and relieve dyspnoea. At the time of the crisis or when the temperature reaches subnormal by lysis the administration of such stimulants as aromatic spirits of ammonia, strychnine and atrophine hypodermically and the application of hot water bottles to feet, legs and body are indicated. Also the administration of glucose intravenously is indicated.

In cases of delayed resolution, the X-rays are highly recommended.

Serum Therapy—Serum therapy is undoubtedly of value and especially in cases of lobar pneumonia if given early and you know which type of organism you are dealing with. It seems to me that the serum should be polyvalent because the pneuonias resulting from pneumococci of different serologic types might be indistinguishable at the onset and if you are going to us serum therapy, it should be done early to get best results.

The pneumonia patient should be kept in bed ten or twelve days after the temperature has reached normal and then another ten days before he is allowed out of the house. Convalesence is usually rapid and the average case does not require any tonics or special after treatment.

The Acute Abdomen*

BY W. H. ANDERSON, M.D.
Booneville, Miss.

*Read before staff meeting at Houston Hospital and published by request.

The acute abdomen holds, has held, and will hold the keenest interest for the general surgeon. No subject could be of more interest to the surgeon of the small hospital. The acute abdomen is full of uncertainty. The conditions are many, the complications may be multiple, and the potentialities are dramatic. The last few years have seen wonderful progress in the diagnosis and treatment of these conditions. But the casualties are still entirely too many. The practitioner needs to know more of the diagnosis. The surgeon can not know too much of the treatment, and the laity must be taught the hazardous possibilities of the acute abdomen.

We shall not attempt to cover all the conditions of the acute abdomen, but we will single out three of the most common.

The most dramatic of all is perforation along the intestinal tract. The onset is very sudden, usually. The general appearance of the patient puts you on guard. The sunken cheeks and the scaphoid abdomen make one suspicious. The marked rigidity, the abdomen that you can jump up and down on and not make a dent, is characteristic. The attitude of the patient is important. He does not want to move. He lies as still as possible; the pulse may be slow and may be full if there has not been too much shock; profuse sweating is usually the order. The history of the case is always of the greatest importance: digestive disturbance periodically for a period of time, improvement and the relapse, is significant. The history of a blow, sudden pressure, or the kick of a mule, any sudden external blow, must be duly considered. The laboratory tests are of not much importance.

The acute abdomen usually calls for explanation. If in doubt operate, as a rule. This is especially true where there is a likelihood of a ruptured viscus from an external blow. If you find a perforation from an ulcer what you do will depend upon the condition of your patient, how many hours after the perforation, and what you are prepared to do, how expert you are in doing a gastroenterostomy, etc. Personally, we have had only four perforations following ulcers, two of the stomach and two of the duodenum. We cauterized the edges with pure carbolic, filled it up with omentum and stitched it over and inserted drainage. We had a hundred percent recoveries.

Acute intestinal obstruction is another abdominal emergency in which time is a very precious commodity. The history again is very important in making the diagnosis. The most important item is a history of a previous operation. Abodominal or pelvic infections should put us on guard. Indigestion and loss of weight in the middle age has much significance. Its train of symptoms and signs are characteristic. You may expect crampy, spasmodic, colicky pain, local mass and gaseous distension. In the beginning the pulse may be slow and there may be an elevation of temperature, but after twelve to twenty four hours the temperature will usually be subnormal, the pulse fast, weak and thready, skin cold and clammy, and the face pinched and anxious. Vomiting of intestinal contents in point of time after onset will be proportionate to the proximity of the obstruction to the stomach. The shock, distress and toxemia bear the same relation also. The blood count is of great importance. You may have a subnormal temperature and a total count of seventy-five thousand leukocytes. The X-ray may be of importance, as the small intestine is not supposed to have any gas normally.

Treatment—Next to an operation morphine has the greatest saving power. It prevents the peristaltic movements from driving the toxines through the walls of the gut. There should be nothing given by mouth. A colon flush may be of benefit. Saline and two and one half percent glucose may help to combat the toxemia and may give strength to the pulse. The stomach pump may be of great advantage. Morphine may relax a band and loose the obstruction. The operation should be done within six hours after the onset if possible. A general anesthetic should be avoided if possible. Novocaine may be all right. Usually you will not do any more than to put a tube in the bowel. Fortunately, the part of the bowel that needs draining will meet you when the abdominal cavity is opened. Just put the tube in and get out. Don't try to wash out the contents. You may increase absorption. Give plenty of clean water and glucose under the skin or in the vein. We have no confidence in the Murphy drip.

The third abdominal catastrophe is like the poor, we have it with us every day. It is appendicitis. Every abdominal pain should be counted appendicitis until it is proved otherwise. This may seem radical, but we are having too many deaths from appendicitis. Some cases of appendicitis will baffle the most expert surgical diagnostician. The average case should be easy. The history is of some importance; previous attacks of cramp colic reinforces the other evidence. The symptoms in their order are of the greatest importance. Pain, tenderness, fever, leucocytosis, one, two, three, four, five. Even a majority of these in their accustomed sequence justify a conviction in a large majority of cases. The most common location of the beginning pain is in the epigastrium, the most uncommon is over the area of the appendix. It may circle around the navel, it may cross or be diffused over the abdomen. It is a pain that holds on. It may get better, but it does not turn loose. It feels like a lump of lead. It jars when the car jolts. It pulls over when the patient would straighten up. Like the thief, it ofen comes in the night. It wakes the patient. It removes many of the horrors of the operating table from its victim. It rebels against food and kicks against a purgative. Pain is a more outstanding symptom in the adult than in the child. Tenderness in the non "put-on" patient by the honestly cultivated touch of the experienced surgeon is the sign of greatest value. Local rigidity is usually present but not always. There may be a mass, but beware of the case that squshes when you press over the appendix. It may be the cold wormy type, but not the hot fulminating variety. The trained finger of the surgeon should become staunch on a sore appendix just like a bird dog on a point. The educated finger will exercise the same care not to scare the muscles as does the dog not to flush the birds. Do not be deceived by the point of tenderness. It varies, but the tenderness is always there. It has its personal characteristics. The tenderness is often more easily located when the patient is lying on his face.

Nausea may follow close after the pain. It may be persistent. It may come only when food is taken by mouth or medicine. It is usually a good index to intensity of the infection.

The temperature curve is rather characteristic. It usually does not occur before four to six hours after the pain. It rises gradually, and in the average case not above a hundred and a half. Some times you may have a gangrenous appendix without any temperature.

The leucocyte count is usually from ten to fifteen thousand in ten to fifteen hours. The polys seventy-five to eighty-five. The total count is of more importance than the differential in the average case. The decrease in eosinophiles is important.

The treatment is surgical. You should give purgative to a case of appendicitis just as you would dynamite to a child to play with. Enemas should be avoided before and after operation. The diagnosis should be made and the operation performed within six hours after the onset. Just a plain operation without any frills is all that is required in the average case. In the pus appendix make a McBerney, remove the appendix if it is handy and leave the incision wide open; no stitches at all is the best plan.

Diabetes Mellitus

BY S. K. GORE
Mantee, Mississippi

Definition—Diabetes mellitus is a metabolic disease, characterized by deficient production of Insulin by the pancreas, causing an increase in the concentration of the sugar in the blood (hyper-glycemia) with consequent secretion of an excess of sugar in the urin (glycosuria).

Etiology—The cause of the disease is unknown, although several factors generally associated with its onset in all probability exert a definitely predisposing influence. The most important of these is obesity.

Joslin in his analysis of one thousand cases shows that the maximum weight of 83 percent was above normal.

Race—Most observers agree that Jews are more susceptable to the disease than other people, but this is probably nothing more than evidence of the fact that they prefer carbohydrate diet and lead sedentary lives. Diabetes is rare in countries where the carbohydrate consumption is low; it is comparatively uncommon in negroes.

Sex—Men are more subject to the disease than women, in the ratio of three to two.

Exercise—Since lack of exercise, or physical activity, is an important factor in the production of obesity, it is always a factor in the etiology of diabetes.

Infections—Some authors ascribe considerable importance to the part played by acute infections in the production of diabetes, and it is well known that a diabetic's tolerance of carbohydrates is temporarily and sometimes permanently lowered by an infectious disease. Peters has particularly emphasized the frequency with which diabetes developed after an acute infection.

Nervous influences—These include all disturbances of emotion, such as, fear, anger, and worry, as well as mental fatigue and mechanical trauma of the nervous system. The part that they played has always been thought important.

A case cited by Foster is interesting as an illustration of the possible action of trauma to the nervous system in producing diabetes.

"A boy four years old was in a runaway accident. He was uninjured but badly frightened, and on the day following the accident began to drink large quantities of water. As the thirst and excessive urination continued, a physician was consulted; sugar was found in the urine. The child lived only four months after the fright."

Morbid anatomy—Diabetes is caused by a functional disturbance of the Islands of Langerhans in the pancreas. The so-called "B-Cells" of these islands normally contain granules, but Beasley has found these to be lacking in most cases of diabetes. The space that they should occupy becomes filled with fluid.

Physiology—It remained for Baning and his Co-workers to demonstrate beyond doubt that a hormone necessary for the oxidation of glucose was produced by the pancreas. This hormone has been named Insulin, and is secreted by the normal pancreas at a fairly uniform rate. The flow increases after meals, particularly after the ingestion of carbohydrate foods. Insulin oxidizes sugar and is also able to convert sugar into glucose. When the supply of Insulin is deficient, part of the sugar available cannot be properly oxidized or reconverted into glycogen, and as a consequence an excess of glucose accumulates in the blood stream. The degree of hyperglycemia depends on the degree of Insulin deficiency, and the amount of available glucose, and these two factors determine the amount of excess sugar in the urine.

Symptoms—The onset of diabetes is usually so gradual that the disease may be unnoticed for months or even years, although the symptoms and signs are quite characteristic. Six of the most typical manifestations are polyuria, polydipsia, polyphagia, loss of weight, weakness, and pruritis. Glycosuria and hyperglycemia are the fundamental abnormalities to which most of the subjective symptoms are referable, and when they are accompanied by the objective symptoms just mentioned, are pathognomic of the disease. Polyuria is often the first symptom noticed by the patient. Ten liters of urine, or even more, may be passed in twenty-four hours.

Laboratory observations—The specific gravity of urine is usually increased to 1025 and 1045, the color is very pale, the odor sweetish, and the glucose content variable, if the diabetes is mild may show only a trace or less than 2 percent of sugar, but when it is severe, the content may rise to 10 percent. As much as 500 to 600 grams may be excreted in twenty-four hours.

Blood—The erythrocyte count may be somewhat higher than normal, but the leukocyte count remains unchanged unless coma or intercurrent infection sets in.

Types—We have two types, the mild and the severe. The mild type is not fatal unless complicated by acidosis. The severe type is characterized by an acute onset and, in the absence of Insulin treatment, a rapid downward course with fatal outcome is inevitable in spite of all dietary restrictions.

Complications—The most common and dreaded is acidosis, which may be classified as mild and chronic, or severe and acute.

Chronic type—This is the less severe; the CO^2 content of the blood sometimes falls from 50 volumes percent to as low as 40 volumes percent, accompanied by glycosuria and ketoneuria.

Acute acidosis—At the onset the face is very flushed, but as the condition progresses, marked pallor ensues. The severe form produces nausea, vomiting, epigastric pain, and discomfort, Kassmaul breathing, and subnormal temperature, and drowsiness finally followed by coma. Other evidences of severe acidosis are dryness of the skin, shrinkage of the superficial tissues, and a red beefy condition of the tongue, throat, mouth, and lips. The breath has an acetone or "fruity" odor.

Diagnosis—Diabetes can usually be diagnosed by the presence of sugar in the urine. The term "renal glycosuria" has been applied to a relatively rare condition which may be distinguished from diabetes by the constancy of the glycosuria, regardless of the carbohydrate intake, the normal quality of the variation of the blood-sugar, and the absence of the other symptoms of diabetes. Alimentary glycosuria includes conditions in which there is a trace of sugar in the urine after excessive carbohydrate ingestion, undue emotional stress, or a combination of the two.

Prognosis—There is no evidence that diabetes is ever cured. The discovery of Insulin has done much to brighten the progosis in diabetes. A great deal still depends, however, on the full co-operation of the patient in regulating the diet and on the exercise of self-control in dietary habits.

Treatment—The cardinal principle involved in any form of treatment in diabetes is that the urine shall be kept free from sugar. This has been the goal toward which every form of diabetic therapy has been directed. The most important advance toward the treatment of diabetes occurred when Banting discovered Insulin in 1922. By the daily injection of this hormone, patients are able to live normal lives on a diet, the calories of which will maintain normal body weight, and the percentage proportion of carbohydrates to protein and fat will be that of the diet fed to normal people.

Insulin treatment—Insulin should be given to all diabetics at any age or at any time during their course of diabetes, when the diet without Insulin is not sufficient to maintain strength, weight, and full capacity to perform their normal occupation. The dosage should be adjusted to maintain a urine free from sugar and a normal blood-sugar. At the beginning of the treatment 15 units of Insulin administered before the morning meal, with 5 units before the evening meal. It may be necessary to increase at the rate of 5 units per dose per day for several weeks before the original sugar is completely eliminated. If after four weeks of such a schedule, we have not succeeded in rendering the urine sugar-free for the twenty-four hour period, or if a given dose of Insulin produces severe hypoglycemic reactions, it may be necessary to curtail one of the doses of Insulin and institute a third injection, which should be given in three or four hours after the second injection depending upon the time the maximum amount of sugar is being excreted.

It is seldom necessary to give a fourth dose of Insulin, but when such is the case, it should be administered at a corresponding interval. The majority of patients can be de-sugarized on two doses of Insulin per day, one morning and one evening, given twenty two to thirty minutes before meals.

The proper adjustment of the carbohydrate consumption to the Insulin dosage, or vice-versa, in order to avoid both the Insulin reaction and glycosuria may require weeks or even months to achieve. It may be necessary in relation to the three meals. Two-fifths of the total carbohydrates for breakfast, one-fifth at the noon day meal, and two-fifths in the evening is the usual method of distribution.

Hypo-glycemic reactions—The symptoms resulting from an over dose of Insulin are either sudden in onset (one to five minutes) or gradual, as, for example, five to twenty minutes. When sudden in onset they are usually severe, resulting in profound weakness, diaphoresis, marked mental confusion, disorentation, diplopia, incoordination, fixed stare, sensory and motor aphasia, and unconsciousness, with muscular tremblings which progress rapidly toward convulsions (epilepti-form in character). The more usual manifestations of hypo-glycemic reactions brought on by overdosage of Insulin are general muscular weakness, momentary mental confusions, loss of memory, a sense of restlessness, profused sweating, pallor or flushing of face, and trembling, weak and hungry feeling. Sugar or orange juice or carbohydrates in any form usually allays these symptoms in from five to twenty minutes.

Adrenalin in four to eight minims in children and 8 to 15 minims in adults serve to counteract the severe reactions temporarily, but should be immediately followed by adequate doses of carbohydrates, 5 to 20 gm. Intravenous glucose is also useful in counteracting severe shocks and may be given in concentration as high as 50 percent (10 to 20 c.c.).

Treatment of chronic acidosis when a non-Insulin-treated case of diabetes shows a mild but persistent acidosis over periods of longer than four weeks, and it is not possible to control glycosuria with a decrease of carbohydrates in the food, Insulin should be used immediately with an adequate increase in the carbohydrates, 100 to 200 gm., in order to eliminate the acidosis.

Treatment of acute acidosis—The patient suffering with acute acidosis requires prompt and energetic treatment. He must be put to bed immeditely and, because of subnormal temperature, he must be kept warm with hot water bottles and blankets. The bowels should be emptied immediately with an enema; cathartics are strictly contra-indicated. Even preceding the above mentioned therapeutic procedures, he should receive 50 units of Insulin subcutaneously, followed by 25 units intravenously. Following this 20 to 30 units of Insulin should be administered at hourly intervals, controlling this dosage by hourly de-

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terminations of glucose in the urine. The most important feature of therapy in combating acute and severe acidosis are: (1) the administration of large amounts of fluid, (2) the administration of glucose in adequate amounts, (3) the adeministration of sodium irons in the form of sodium chloride and sodium bicarbonate.

DISCUSSIONS OF DR. GORE'S PAPER

Dr. Aycock—I have enjoyed this paper very much, and, although I have never had very much experience in this subject, I should like to say this. In a case where there is sugar in the urine without blood sugar, diet and insulin are the only things to use.

Dr. Burns—While we are breathing the atmosphere of the Memphis medics we might hear from a young man who, though an internist, might rank as high as some of our veteran and noted surgeons. We are speaking of Dr. Whitman Rowland and we should be glad to hear what he has to say on the subject.

Dr. Rowland: Dr. Gore's paper was very interesting and I am glad to see a revival of essays on Diabetes. Back in 1921, soon after the discovery of Insulin by Banting, the journals were full of discussions of Diabetes Mellitus. There followed a period of time when very few articles were noted. Recently there has been a revival of interest. This has come about through the realization that, in the past, our diets have been insufficient in quantity for the average diabetic. More carbohydrates and more calories are now being given to the diabetic patient. One must realize that it is not the glycosuria nor hyperglycemia itself which produces the dire results but that it is due to an incomplete metabolism of fats. The ultimate metabolic destiny of fat is carbon dioxide and water. A piece of fat is split into simpler fatty acids in the duodenum and then through a process of metabolism goes on down through beta-oxybutyric acid, carbon dioxide and water. Woodyat aptly stated that the fats burn in the fire of the carbohydrates. In order for this complete metabolic activity to take place, one must be utilizing carbohydrates. In diabetes, with insufficiency of specialized pancreatatic tissue, the carbohydrates are not utilized, consequently the fat metabolism is incomplete and stops at beta-oxybutyric acid, acetone and diacetic acid. This brings about the condition of diabetic acidosis and coma. Right here it might be stated that it is dangerous advice to instruct the diabetic patient to leave off his sweets entirely. Recently there has been quoted, in the French literature, some criticism of Insulin. It has been noted by French observers, that people who have taken Insulin over a long period of time, show some myocardial degeneration. One wonders whether this is actually due to the Insulin or whether it is due to a decrease of glycogen content of the heart muscle, the result of the diabetes. To go back to the question of diet. Practically all adult diabetics should have from 1,800 to 2,500 calories per

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day; regardless of their status as a diabetic. It is still important to keep in mind the fatty acid glucose ratio. That is, a fatty acid glucose ratio of approximately one to one and one-half or one to two. It has been shown that one gram of glucose will carry to complete metabolic activity, approximately two grams of fat. Consequently, when a diet is planned this ration of one to one and one-half or from one to two should be kept in mind. I should like to emphasize again that it is dangerous to instruct the diabetic patient to cut out all sweets and leave him with this. A great advancement today is along the lines of diet, that is, allowing more liberal carbohydrate intake. Those who have had experience with Insulin can not help but be impressed with its magical action in diabetic coma.

Dr. Eckford: I would suggest that in treating the ordinary case of diabetes have the patient get a diet as low in carbohydrates as he can live on, then fix the insulin necessary to take care of him. This method proved the only satisfactory one in my own experience and I have adopted it with my patients. And the diabetic should be fed more, for as a usual rule we cut the food supply too low.

Dr. Bryan: We are discussing the biggest subject we have to deal with. Any doctor who practices medicine nowadays sees many cases of diabetes. I should like to take issue with Dr. Holder on it being a disease of middle age. I am of the opinion that there are more people who die of diabetes during early infancy than any other time of life. Very often is the case when a baby with diarrhea may be given a little insulin and his health will return, cheeks grow rosy again and pick up. The word diabetes is a misnomer (means a discharge). We can't cure a diabetic but we can make him comfortable for a few years. And my opinion is that the death rate will increase as in appendicitis the malfunction of the pancreas, which eventually leads up to cardiac sclerosis is the real cause of diabetes. And we have to know something about the internal secretions. By observing closely the apparently well patient one can discover cases of hypo-and hyper-pancreanism. Many times in hypo-pancreanism with a little insulin along, thus resting the pancreas, sugar in the urine might be cleared up and soon do without the insulin. The other type, hyper-pancreanism, when the patient is depressed, might lose consciousness while fishing, or wake up at night starving, become too weak to work—the pancreas is over working and will soon play out itself and such a person will no doubt develop diabetes.

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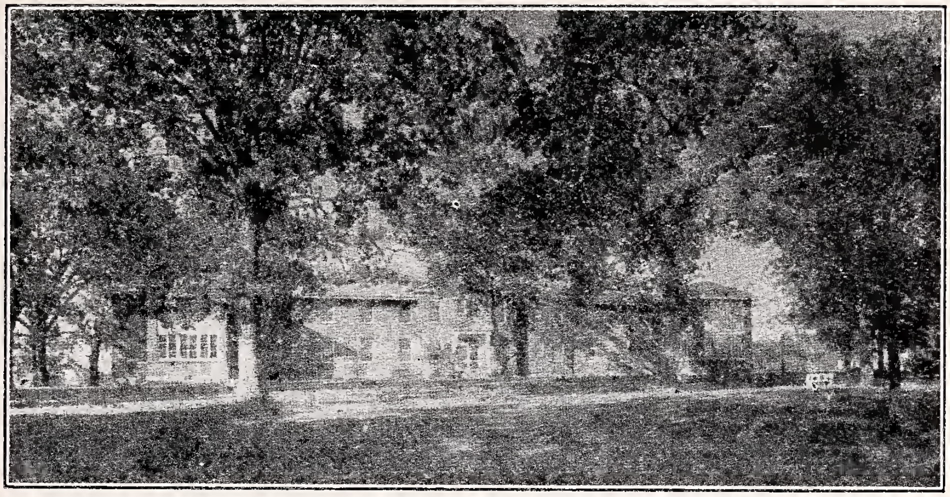

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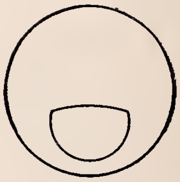

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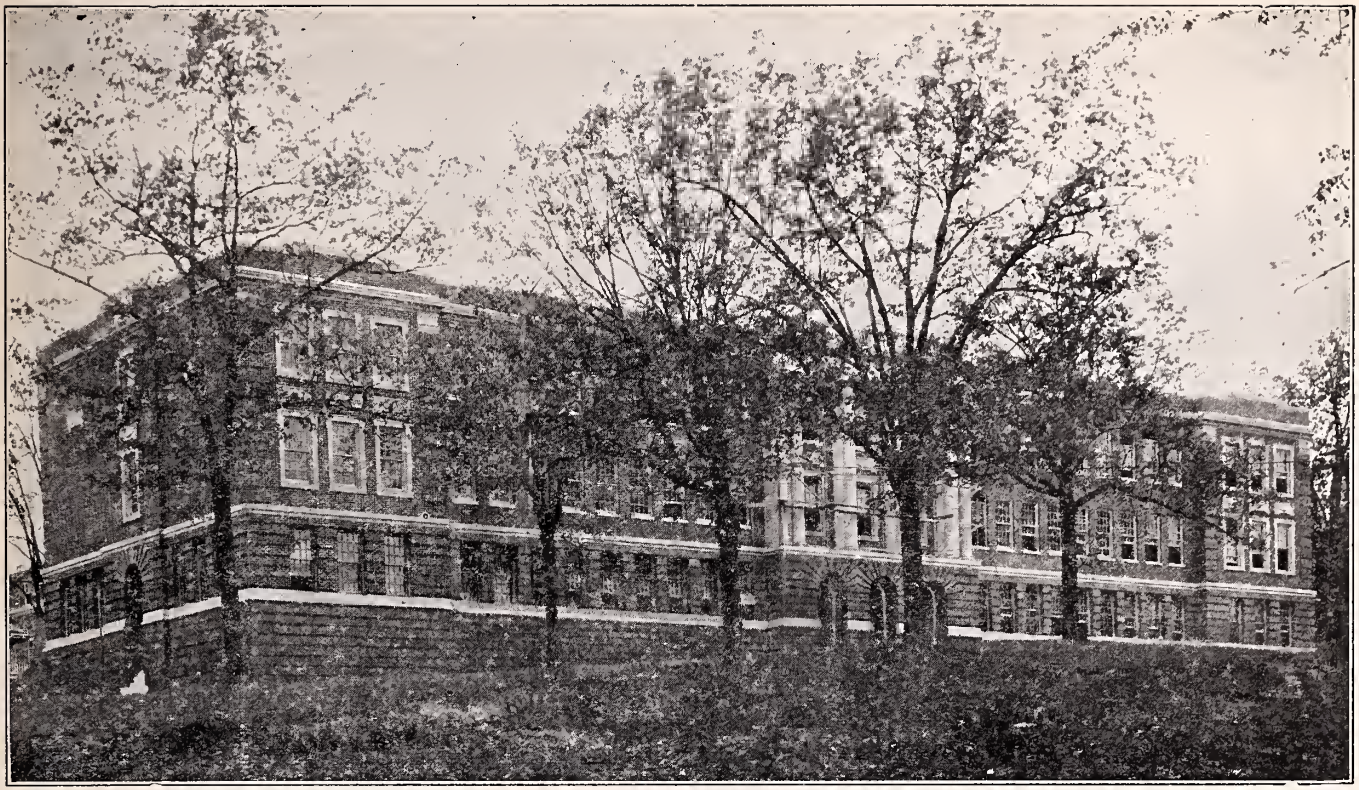

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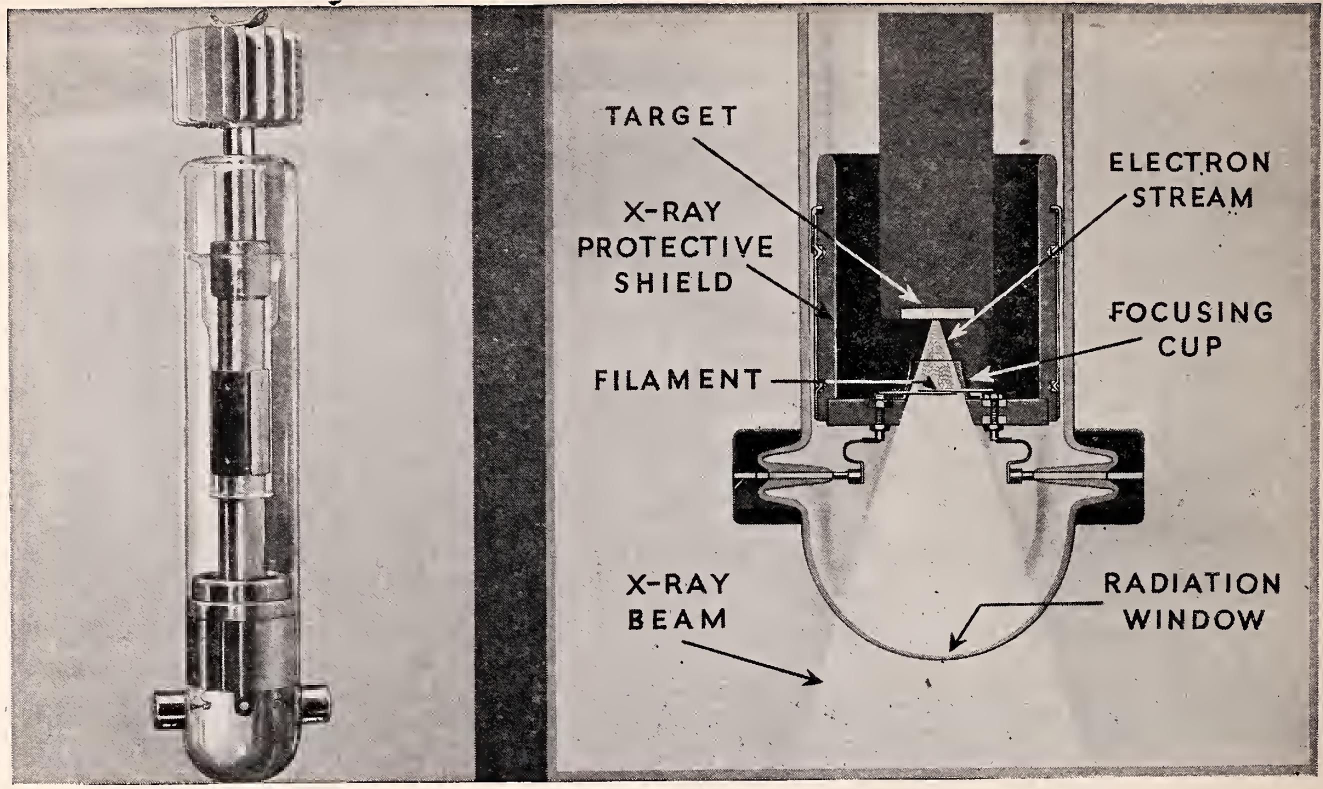

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Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1870.

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The recent Annual Conference of Health Officers, Sanitary Engineers, and Sanitary Inspectors, which was held in Jackson, was the most successful ever had. There were one hundred and twenty-three in attendance and the program was excellent. The out-of-state speakers were: Dr. W. A. Evans, Professor of Public Health, Northwestern University, and Health Editor of the Chicago Tribune; Dr. L. M. Graves, Health Commissioner of Memphis, Tennessee; Dr. G. A. Wheeler of the U. S. Public Health Service; and Dr. Allen W. Freeman, Professor of Public Health Administration, Johns Hopkins University, Baltimore. Dr. Freeman gave a two hour talk each morning of the conference.

The Copiah County Health Department will be continued on full-time basis. Because of lack of appropriation, it was thought that it would be necessary for the department to close; however, additional funds have been secured.

Dr. F. L. McGahey of Calhoun is now president of the Northeast 13 County Medical Society. We congratulate him and the society also. He will hold the steering wheel steady and glide over the rough places with ease and safety. We will have more to say about him later.

The Mississippi Doctor extends its sincerest sympathy to Dr. M. Q. Ewing in the loss of his brother.

Take a glance at the lineup for the Mid-South Post Graduate Assembly February 15-18 and then make your arrangements to get off.

The first duty a doctor owes to his profession is to pay his dues and the next is to attend the meetings. The doctor who does not pay his dues will finally go down as surely as did the Titanic.

We were exceedingly sorry not to be able to attend the meeting at Aberdeen. The program was a good one. The sleet was slick and the roads were dangerous. We will all be present at the next meeting.

We feel keenly the loss of a member of our editorial staff, Dr. W. C. Brewer. He was one of our society's most successful surgeons. He was an able financier. He was a close student in the field of medicine and kept well informed on matters of general interest. He was devoted to his profession and was always dogged on the job. He was a loyal friend. He was a valuable citizen. Our society regrets very sincerely his untimely death and it feels keenly his loss.

It has been suggested by one of the leaders and friends of the community hospitals that the cost per patient be decided upon by a committee from the legislature and the medical and nursing profession and let this be the price charged per day for charity patients. This is a mighty fair proposition. Our five state charity hospitals cost us one hundred thousand dollars before even one patient is treated, in salaries, interest and upkeep and then the "legislators" roar about these hospitals treating patients cheaper than the small hospital. We are going to take our flash light and go out and hunt for one man through whose brain the importance of the community hospital can percolate.

We are delighted to know that Dr. M. M. McMillan of Tupelo is able to be back in the harness after a serious operation. Dr. Mack is truly one of the able practitioners of North Mississippi.

Eternal vigilance is the price of success in the practice of medicine for a certainty.

For several reasons we are combining the December and the January issues into one this month. We are glad to have the papers on public health which you will read with much profit.

The following Mississippi physicians were awarded in December, fellowships by the Commonwealth Fund of New York City:

Dr. D. T. Brock, McComb; Dr. J. E. Hewitt, Summit; Dr. A. J. Fortinberry, McComb; Dr. S. Paul Klotz, McComb; Dr. H. F. Tatum, Meridian; Dr. W. N. Jenkins, Port Gibson; Dr. L. L. McDougal, Booneville; Dr. G. C. Terrell, Prentiss; Dr. J. B. Thigpen, Bay Springs; Dr. J. E. Ellis, West Point.

General News

"Dr. F. G. Riley, one of Meridian's eminent physicians, recently formed, with other Meridian physicians, a medical and surgical clinic. Dr. Riley's hospital, which has beeen given to children's work mainly, is now connected with this new clinic and is used for the treatment and hospitalization of all kinds and classes of patients. In conjunction with his treatment of children's diseases which Dr. Riley will continue as his special practice, Dr. G. L. Arrington will be associated also as pediatrician. Others of the new staff include: Dr. M. L. Flynt, Surgeon and Obstetrician; Dr. C. J. Lewis, Surgeon and Obstetrician; Dr. C. R. Stingily, X-Ray and laboratory; Dr. T. D. Bordeaux, internal medicine.

Dr. Riley and these doctors associated with his in this new venture for more efficient modern medicine are to be congratulated, and Meridian should be proud of this fine new clinic and the service which it will provide."

List of Speakers at Mid-South Post Graduate Medical Assembly, Memphis, February 14-17, 1933.

Dr. Isidore Cohn—Surgery—New Orleans, La.
Dr. W. Wayne Babcock—Surgery—Philadelphia, Pa.
Dr. Duane M. Carr—Chest Surgery—Ann Arbor, Mich.
Dr. Clarence M. Grigsby—Medicine—Dallas, Texas.
Dr. Logan Clendening—Medicine—Kansas City, Mo.
Dr. Lawrason Brown—Tuberculosis—Saranac Lake, N. Y.
Dr. Thos. R. Brown—Medicine—Baltimore, Md.
Dr. Jos. Leggett Miller—Medicine—Chicago, Ill.
Dr. Russell Cecil—Medicine—New York, N. Y.
Dr. J. C. Litzenburg—Obstetrics—Minneapolis, Minn.
Dr. Frank Howard Lahey—Surgery—Boston, Mass.
Dr. Chas. G. Kerley—Pediatrics—New York, N. Y.
Dr. J. P. Simonds—Pathology—Chicago, Ill.
Dr. J. A. Kolmer—Pathology—Philadelphia, Pa.
Dr. Wm. P. Graves—Gynecology—Boston, Mass.
Dr. Jos. L. Baer—Obstetrics—Chicago, Ill.
Dr. Alexander Randall—Urology—Philadelphia, Pa.
Dr. John N. Wheeler—Eye—New York, N. Y.
Dr. Jos C. Beck—Ear, Nose and Throat—Chicago, Ill.
Col. Chas. F. Craig—Medicine—New Orleans, La.
Dr. L. T. Royster—Pediatrics—University, Va.

Resolution of Northeast Miss. 13 County Medical Assn.

"The boast of heraldy, the pomp of power,
And all that beauty, all that wealth e'er gave,
Await alike the inevitable hour,
The paths of glory lead but to the grave."

Dr. Walter C. Brewer Columbus, Mississippi, was born in 1876 and died Nov. 28, 1932.

For many years a loyal member of this society. Upright as a man, learned in his profession, he leaves a life worthy of emulation.

Believing in thorough preparation, he was a continuous student, taking frequent Post courses, keeping himself in the forefront of medical progress and learning.

He had an extensive practice which was built and maintained by honesty, ability and efficiency.

He was a graduate of the University of Mississippi, 1898, and of the School of Medicine, Tulane University, 1901, and short courses in Chicago, Cleveland, Rochester, and at Harvard Medical School.

THEREFORE, BE IT RESOLVED: That we have lost a faithful friend; Columbus, an honored citizen; Our Society a trusted associate; and the Medical profession of Mississippi, a Shining Light.

W. A. JOHNS
W. C. WALKER
J. RICE WILLIAMS, Committee.

Financial Statement Northeast Mississippi 13 County Medical Society as of Dec. 7, 1932

Balance in bank as of Dec. 4, 1931	$ 62.05
Receipts 1932 membership 129 members	774.00
Total receipts 1932	836.05
Expenditures:	
T. M. Dye State Secty. 129 members	$516.00
Mississippi Doctor 130 subscriptions. This includes subscription for the Secretary. There are no dues paid for County Secretaries to the State Association. This explains the difference between the 129 members and the 130 subscriptions	130.00
Stenographic work	10.00
Printing programs for the year	43.55
Stationery	35.62
Postage	38.98
Telephone & telegraph	6.48
Tax on checks	.36
Total	$780.99
Balance in bank Dec. 7, 1932	$ 55.06

Program

NORTHEAST MISSISSIPPI THIRTEEN COUNTIES MEDICAL SOCIETY
DECEMBER 20, 1932

Luncheon—
(Please Be On Time) Dining Hall, Baptist Church
Business Session—
Meeting Called to Order W. C. Spencer
Invocation Rev. W. R. Lott
Secretary's Report.
Election of Officers
President this Year from Calhoun County
Old and New Business.
Scientific Session—
The Benefit of X-Ray Studies in Diagnosis W. R. Betha, Memphis
Present Trends in Public Health F. J. Underwood, Jackson
Cardiospasm W. H. McRae, Corinth
Harpes Zoster, or Zona, with Report of an Interesting Case J. G. Lilley, Tupelo
Adjournment—

The Southeastern Congress Announces Its Fourth Annual Assembly

Atlanta Biltmore Hotel, March 6, 7, 8, 1933

The following prominent surgeons and internists will appear on the program:

Dr. Tom G. Orr, Kansas City—The Essentian Factors in the Treatment of Acute Peritonitis.

Dr. Walter E. Sistrunk, Dalls—Subject to be announced later.

Dr. C. W. Roberts, Atlanta—Subject to be announced later.

Dr. Geo. W. Crile, Cleveland—Peptic Ulcer —Lantern Slides.

Dr. W. D. Haggard, Nashville—Toastmaster.

Dr. Chevalier Jackson, Philadelphia—Diverticula of the Esophagus and Hypopharynx. Lantern and Motion Picture Demonstration.

Dr. Charles Bagley, Jr., Baltimore—Subject to be announced later.

Dr. W. E. Lower, Cleveland—The Various Functions of the Testes; an Experimental and Clinical Report.

Dr. Hugh Cabot, Rochester—Subject to be announced later.

Dr. Hubert A. Royster, Raleigh—Sidelights on the Pathology of Appendicitis.

Dr. E. W. A. Ochsner, New Orleans—The Relative Value of Sclerosing Agents in the Treatment of Varicose Veins.

Dr. Dean Lewis, Baltimore—Muscles, Nerve and Blood Vessel Injuries of the Extremities.

Dr. Carl A. Hedblom, Chicago—The Diagnosis and Treatment of Tumors of the Thorax.

Dr. W. Wayne Babcock, Philadelphia—The Vaginal Approach to the Peritoneum.

Dr. W. R. Houston, Augusta—Subject to be announced later.

Dr. Curtice Rosser, Dallas—Problems Confronting the Proctologist.

Dr. Irvin Abell, Louisville—Tumors of the Breast.

Dr. Robert Wilson, Charleston—The Fundamentals of Surgery—a Medical Viewpoint.

Dr. Cecil Rigby, Spartanburg—Subject to be announced later.

Dr. Russel O. Lyday, Greensboro—Surgical Progress from a Physiological Standpoint.

Dr. Vilray P. Blair, Dr. James Barrett Brown, St. Louis—Cancer of the Mouth.

Clinics will be held also. The complete program will be mailed out about February 15, 1933. Watch for the program and prepare to attend.

B. T. BEASLEY, M.D., Sec.-Treas.

Ole Miss Medical News

By Woodard D. Bracham

James Burdine Looper, B.S., M.S., Ph.D , Professor of Histology and Embryology.

A native of South Carolina, Dr. Looper graduated from Furman University (Greenville, S. C.) in 1922. He served as Student Assistant in Chemistry during the last two years of his stay at that institution; and the year following he taught Physics and Chemistry in the Greenville, S. C., High School. The year 1923 marked his return to Furman University where he was Instructor in Biology and Physics for one year. The next year he enrolled in the University of Virginia of Virginia to work on his Master's degree. Here he received that degree in 1925, and held a Student Instructorship 1924-1926.

Dr. Looper came to the University of Mississippi School of Medicine in 1926 to act as Associate Professor of Histology and Embryology, a position which he held until 1929 at which time he was elevated to Professor of those subjects. He received his Ph.D. from University of Virginia in 1927, and did research work with Dr. H. E. Jordan, of that University, during the summers of 1926 and 1928. The summer of 1929 was spent in study and research at Marine Biological Laboratory, Woods Hole, Mass., and the following summer he studied human Anatomy at University of Michigan. He also studied Physiology at the latter institution the next summer. Dr. Looper was Acting Professor of Histology and Embryology at the University of Tennessee 1st quarter, 1932.

He is a member of Phi Beta Kappa, Sigma Pi, American Association of Anatomists, American Association for the Advancement of Science and Mississippi Society for the Preservation of Wild Life. He was a member of the Virginia Academy of Science 1925-1930, and was chairman of the committee for organizing Mississippi Academy of Science, 1929. He is now secretary of that organization. Dr. Looper received the First Walker Prize for research in Zoology offered by Boston Society of Natural History, 1926.

His publications as follows: (1) Cytoplasmic fusion in Actinophrys sol. Jour. Exp. Zool. v. 50, 1928. (2) Obervations on the food reactions of Actinophrys sol. Biol. Bull. v. 54, 1928. (3) A histological study of the colic caeca in the Bantam Fowl. (J. B. Looper and Margaret Haase Looper) Jour. Morp. and Phys., December, 1929. (4) A study of the reticulum (argyrophile fibers) in the ovary of the Albino Rat. (ibid) Abstract in Anat. Rec., Apr., 1930. (5) The nutrition of the ovum of Hydra viridis. Biol. Bull. v. 50, 1926. (6) A histological study of the Thymus gland in Alligator mississippiensis. Abstract in Anat. Rec., Apr., 1930. (7) The histology of the Thymus gland of the Box-turtle, Terropene carolina, with special reference to the concentric corpuscles of Hassall and the eosinophylic granulocytes. (H. E. Jordan and J. B. Looper) Anat. Rec. v. 40, 1928. (8) The comparative histology of the lymph nodes of the Rabbit. (Ibid) Am. Jour. Anat. v. 39, 1927. (9) Infection experiments with Hydramoeba hydroxena. (B. D. Reynolds and J. B. Looper). Jour. Parasitology v. 15, 1928.

Billy Sylvester Guyton, B.S., M.A., M.D., Oph.D., F.A.C.S., Professor of Minor Surgery.

Born and reared in Mississippi, Dr. Guyton received the B.S. degree from Mississippi College in 1908. Two years later he fulfilled the requirements for the degree of Bachelor of Science at the University of Mississippi, and in 1911 graduated with the title of Master of Arts, receiving at the same time his Medical Certificate earned by completion of the work of two years in the University Medical School. He transferred to the School of Medicine of the University of Virginia from which he received his Medical Degree in 1913. From 1912 to 1913 he served as Intern in the Martha Jefferson Sanatorium, Charlottesville, Va.; and was Intern in the Orange Memorial Hospital, Orange, N. J., the following year.

Dr. Guyton returned to Mississippi in 1914 and engaged in the general practice of Medicine for fifteen months. He accepted the Professorship of Bacteriology and Pathology in the University of Mississippi School of Medicine in 1915 and occupied that position for five years. After that period had elapsed, he resigned to devote his entire time to the eye, ear, nose, and throat specialty, having received the title of Doctor of Ophthalmology from the University of Colorado in 1919. He resumed his official connection with the Ole Miss Medical School in 1926 as Professor of Minor Surgery and has held that position since that time.

Dr. Guyton has done post-graduate work in New York, Chicago, and Vienna. He is a Fellow in the American College of Surgeons, and also in the American Academy of Ophthalmology and Otolaryngology. He is a member of the American Medical Association, the Southern Medical Association, and the North Mississippi 6-County Medical Society. He is also affiliated with Phi Beta Kappa, Phi Beta Pi, and Sigma Chi.

Dr. Merritte W. Ireland, Surgeon-General of the U. S. Army (Retired), and Dr. William D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association, inspected the Ole Miss Medical School December 8th.

Thousands of Mississippians and the many friends of the University of Mississippi School of Medicine in other states are happy that the American Association of Medical Colleges placed the Ole Miss Medical School on the accredited list with a probationary standing for the next year. They feel that the rehabilitation measures initiated by the central board of trustees of the institutions of higher learning Mississippi which resulted in the reinstatement of these institutions into the Southern Association of Colleges and Secondary Schools will result in the continuance of Mississippi's only medical school.

Upon his return from the recent meeting of the Council on Medical Education and Hospitals of the American Medical Association, Dean Mull announced that the University of Mississippi Medical School would be allowed to keep its standing as an A-grade school on probation for this year.

The council held its sessions at the Benjamin Franklin Hotel in Philadelphia November 14th, 15th and 16th.

Correction: The typographical error in the sketch about Dr. Mull in the October issue should have read as follows: Dean Mull has been a member of the American Association of Anatomists since 1922.

A number of prominent members of the medical profession observed Homecoming Day at Ole Miss November 12th. It was good to see them, and their kindly feeling for the Medical School is appreciated.

Training Period For Reserve Officers Announced

From February 12 to 25, 1933, there will be a training period for Medical Department Reserve Officers of the Army and Navy, made possible at the University of Washington Medical School, St. Louis, Missouri, by the courtesy and enthusiasm of the faculty of this school in co-operation with the Medical Departments of the Army and Navy.

While this is classed as an "inactive duty period" and is without pay or allowances to the participants, the time spent is recognized for the same credits as though it were an "active duty" period. The exceptional clinical advantages of this great medical center, combined with the advanced military and naval training, make possible a very profitable two weeks. The training is open to all Medical Department officers of the Army and Navy reserves, or the National Guard.

The program of the clinics will be under the direct supervision of the faculty of the Washington University. The military instruction, which for the first time includes instruction with reference to the medical service of the Navy, will be under the direct supervision of Colonel George A. Skinner, Medical Corps, United States Army, Corps Area Surgeon, assisted by Lieutenant Commander Reuben H. Hunt, Medical Corps, United States Navy.

Applications for attendance should be forwarded to the Surgeon, Seventh Corps Area, Omaha, Nebraska.

Urban Health Problems—Their Solutions*

BY DR. L. M. GRAVES,
Superintendent Memphis, Tenn., Health Department
Memphis, Tenn.

The fundamental principles of public health are the same in every geographical area and in all population groups. Concentration of population increases the intensity of many of the problems and calls for more heroic action and more precision in methods of approach than are required in less densely populated areas. The average southern city seems to focus most of the common problems, both in kind and in intensity. So numerous are the problems that time will not permit nor would it be practical to attempt a detailed discussion in a paper of this character. The writer has, therefore, taken the liberty to point out some of the peculiarities of city health work, mention a few of the problems and to discuss some of the administrative difficulties in this type of work.

If one whose previous experience has been largely rural undertakes urban work he finds that the variation in the characteristics of the population are wider in the city. He finds both extremes in intelligence, in health consciousness and in the degree of co-operation with health department activities. This characteristic will be noted in the professional groups as well as in the lay population. This necessitates a carefully prepared program and rather strict policies of procedure. Urban work in most instances is older than rural. This means that many preventive principles are better understood by at least a part of the population. It means, also, however, that many erroneous and antiquated ideas have been firmly fixed. Someone has advised that we, "Be not the first by which the new is tried, nor yet the last to lay the old aside." This philosophy seems to find its extreme application to public health information. We sometimes find it difficult to get over new ideas to our public, but it is perhaps more difficult to dislodge misinformation that has been accepted for a time. Our failure in the former is often due to the fact that we have overlooked, or failed in the latter.

A city health department was formerly a sort of "catch all" for governmental functions which seemed to fit into no other department of the government. This forced the health department to give much of its time and attention to matters which had little or no relation to public health. Garbage collection, pestiferous mosquito control, street cleaning, and weed cutting are examples of some of these activities.

Not only was the health department a "catch all" for miscellaneous activities, but all too often its personnel was composed largely of political employees and old or injured policemen, firemen, or other persons whose period of usefulness in their original field had passed.

Most of our cities have safe water supplies and approved sewerage disposal systems but often there are many dwellings not connected to the water or sewer system. The health department is interested in securing these connections, but merely serving notices on the occupants will not accomplish this unless there is a systematic method of follow up. When new lines are extended it has been our policy to serve notices on all property owners to connect. These notices give a specified time limit and the records are so filed that they come up on the expiration date. A follow up inspection is immediately made. If the work has not been done a second notice with a shorter time is served and followed up in the same way. If this is ignored the offender is summoned to the office to show cause why he should not be arrested. If there is no response to this a warrant is sworn out and the party arrested. In no instance have such offenders escaped fines. If he responds to any of notices but states that he is unable to do the work, his financial status is investigated and is justifiable, upon his written request and upon the temporary approval by the inspector of his old facilities, he will be given specified extension time, at the end of which the work must be completed or he must come in and convince us that it is necessary for him to have another extension. This continues until the work is completed. There is no more chance for us to lose sight of the matter than for the bank to forget the note you owe.

Poor housing is a problem in most of our cities. Housing conditions in the tenement districts of cities are no doubt responsible for much sickness and death. It is difficult to correct many of these conditions that already exist. The houses are private property and cannot be arbitrarily condemned. The solution probably lies in improved building regulations. If such regulations are strictly followed and old buildings are condemned and removed as rapidly as justifiable, this condition will gradually be corrected. The City of Memphis has recently passed an ordinance prohibiting the construction of dwellings which do not front on dedicated streets. The ordinance also requires a minimum yard space which is based on the height of the building.

Careful attention to planning will prevent many future dificulties and the health officer should interest himself in this matter. The building of streets and construction of buildings in suburban areas which do not meet the standards of the city code will be a source of trouble when such areas become a part of the city.

Industrial hygiene is becoming an increasingly important problem in the South. Fortunate will be the city which works out and initiates a practical program in this important field before the city becomes industrialized. The need for such programs in our cities emphasizes the need for personnel competent to handle such matters intelligently.

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*Given December 12, 1932 at Jackson, Miss., at the 20th Annual Health Officers Conference.

The presence of a large negro population with its attendant high general and specific death rates is a vital problem in most southern cities. Too long we have looked upon some health measures as luxuries and because of racial prejudice the negro has been denied the protection of such measures. This is not only inhuman and un-American but is unwise from a selfish standpoint. As we improve the health of any part of our population we improve the health of all. We have found the negro worker, properly supervised, more efficient in dealing with the negro race, particularly in educational matters. Thirteen negro nurses on our staff registered approximately one hundred per cent of the negro prenatals in the city in 1931.

In the administration of a city health department some problems arise which require tactful handling. In every city there are many voluntary agencies who are interested in some public health problem. The establishment of proper relationship with these organizations is important. Most of them can be used by a wise health officer to help accomplish his program. If he does not use them he will find that these organizations will use him—disrupting the balance of his program; or, working independently, will frequently be a source of great embarrassment.

Political pressure is too often allowed or even invited to interfere with the work of the health officer. This is particularly true when the pursuit of a program of sanitation requires the expenditures for public health are quite small in proportion to the amount spent for other important activities. The accomplishments of the most efficient health department are so much more intangible to the public and to appropriating bodies than the building of streets, school houses, etc., that it is much easier to secure funds for these purposes.

It would seem presumptuous to suggest to this group the importance of beginning and continuing a program of education with the officials to whom the health officer is responsible. It is mentioned in this connection merely for emphasis. Every opportunity should be utilized to develop in these officials a health consciousness. They should be kept as nearly as possible acquainted with the conditions, the needs and the possibilities in the community. We have found it helpful to prepare written policies for all routine procedures not only for the guidance of employees but for the education of the officials. If such policies are clearly written and logically presented there is usually little difficulty in having them understood and approved by those in authority. When this has been done these officials cannot consistently allow political pressure to interfere with the program. They are not only less inclined to permit this but they are armed with information which will enable them to answer the arrangements of the person making the request. It is sometimes helpful when such situations can be anticipated to explain the matter carefully to the official before he is approached by the one requesting the special favor. If an "Influential politician" requests a favor which violates a policy of the department his request should be handled as diplomatically as possible. The whole policy and the reason for its existence should be explained to him and he should be shown that you cannot violate it "even for him." If it is felt that he has not been satisfied and that he may go to the higher authority much may be accomplished by going first to the higher authority and explaining the matter, pointing out the fact that you could not grant such favor without destroying the policy which he had approved.

A properly prepared budget is perhaps the best weapon with which to secure appropriations. It should be carefully analyzed to show in detail the activities for which all funds will be spent. When such a budget is presented to an appropriating body it is immediately impressed with its own responsibility for the services outlined. Reducing the budget means reducing the service, and it is the appropriating body and not the health officer making the reduction.

The question of trained personnel is most important. Selections of division directors should be made with the greatest care. For these key positions people who are research minded and who can initiate and prosecute an intelligent program are essential. A well trained nursing supervisor, a sanitary engineer who keeps himself abreast of the times, a competent epidemiologist and a reliable laboratory director are indispensable. Every division should be encouraged to do original study on some project—learn to make correct observations and to draw logical conclusions from the data collected. All current literature should be read on these subjects. The training of much of the subordinate staff will have to be done by the department in most of our cities. Carefully planned courses of instruction should be given all employees including examination, grading, and the like. This stimulates all to continued study and helps to select those who are more competent for added responsibility, and is quite discouraging to the incompetent. Such instruction and examinations rapidly counteract the common impression that any untrained and incompetent person can do public health work. It is also a great aid in weeding out undesirables.

Staff conferences and programs broaden the viewpoint of the members and stimulate more understanding and co-operation between divisions.

The health conditions of the trade territory of any city greatly influence the conditions in the city. The vital statistic records of the city likewise reflect the health status of the surrounding area. The population of the city and of the adjacent territory is constantly intermingling. This means the ready spread of communicable disease in both directions. The city serves as a medical center and many of the cases of illness in the rural area are treated in the hospitals of the city. Deaths from these cases increase the death rates of the city. A most striking observation to us has been the vastly larger number of cases of communicable disease coming from counties without organized health service than from counties which have such service. A similar thing is true with regard to the number of instances in which sources of infection in our own citizens can be traced to these counties. It is evident, therefore, that every city should be interested in and should encourage in every possible way the establishment of full-time health departments in all of the contiguous territory.

May I summarize by saying that:

1. The fundamental principles of public health are the same in all areas.
2. There are certain characteristics peculiar to urban work.
3. Most city health departments have passed thru a period in which many irrelevant activities and many inefficient, political employees have been thrust upon them.
4. There are a few problems demanding special attention in southern cities today.
5. The solution of most of the specific problems and many of the administrative difficulties will depend upon: (1) Establishment of proper relationship with non-official agencies. (2) Education of higher governmental officials, including the securing of their approval of established policies. (3) Submission of carefully prepared budgets. (4) Proper selection of staff executives. (5) Continued study by employees. (6) Establishment of full-time health service in contiguous area.

Utilizing Organized Groups In A County Nursing Program*

BY AUGUSTINE B. STOLL, R. N.

In common with the rest of thinking people of today, we must seriously consider how economies of time, of service, and of money can be most safely arrived at in a county health department. We are apt to think of curtailment of a program as it is affected by finances, and to rush in headlong with the praiseworthy determination that by increased effort we will give the same service as formerly. This is impossible, and we should pause and consider where lies the greatest need for our services, whether we shall continue established practices, or if they are well developed, relinquish the major interest in them to others and undertake services not adequately cared for. During this analysis, we should consider assets that we have not heretofore used extensively. Public interest and co-operation—we are not good salesmen and we are reluctant to talk of our accomplishments. It is the tradition of the medical group, and of its coworkers—the nursing profession—to silently do our job, as well as possible, confident that through its value it will prove itself. This is not true and we should shake off this threadbare belief. We cannot carry on a full program if we are financially limited, and if there is ignorance and doubt concerning the value of public health, this financial curtailment of funds will continue.

How many of us have heard vague remarks like this: "Oh, yes, I'm for the health department. It's a fine thing." How many of us have had courage to ask why he is for it. Often he doesn't know; he has heard somewhere it had helped somebody. This isn't a positive stand.

All of this we admit, and the question still clamors for an answer. How shall we, unskilled in the methods of health education, untrained in co-operating with other organizations—how shall we reach out and arrest the interest and support of the average citizen?

First of all, comes the greatest difficulty in the problem—we must change ourselves—our point of view, become better informed of what others are successfully doing, and then do it! Too often we are carrying with us, as excess baggage, preconceived ideas or attitudes produced by old habits of thought. We escape behind the remark—"We give the people what they want,' and ignore that what they want may be what we have taught them to expect and this may show little change or growth through the passing years.

The talk of health committees is bewildering to us. We are apprehensive of where they may lead us and are suspicious of this new thing. Yet, old ways are not working and together we must consider innovations if we are to continue to exist.

Our greatest apprehension is that committees formed to disseminate knowledge and interpret our work to the communities, may grow too strong and become steering committees. Such steering or administrative committees conflict with the policies of the State Department of Health and could degenerate into groups representing factional interests and ambitions. May it be emphatically repeated that the suggested health committees do not belong to this class, and it is the responsibility of the director of the department that they be held to their own, very broad functions.

In a recent medical magazine, an article stated that many states have reported that the county health departments, that had been forced to discontinue, were those that had little or no organized health committees.

The word 'organize' has a discouraging sound—how does one do it? First, let us consider a rural community with perhaps a small town of 200 inhabitants. You will find that there is some form of organization already active there, perhaps, several. Sometimes it's a small woman's club, a literary society, a parent-teacher association, or a patrons' union. Even in the smallest community, you will find the nucleus of what you are looking for. Let lists of all the members of the societies, men and women. See how many are members of several of the clubs, for that may mean public spirit. Consider them according to their availability in relation to the time they can give, their influence in the community, how they work with others, their vision, and their ability. Under this last heading, add their chief interest or activity. If possible, include in one of the committees the wife of the supervisor of the district, and also a representative of the teaching profession. This cataloguing of individual assets can be best handled through a card index, or the results may be tabulated in a notebook. But be sure, that if time be spent in this way before a committee is formed, it will be many times worth it, through mistakes avoided. Get impartial opinion concerning those seeming to be best fitted for the work from reliable sources such as home demonstration agents, school principals, and outstanding citizens.

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*Read at the Annual Health Workers' Conference, held in Jackson, December 12-14, 1932, by Miss Augustine B. Stoll, R. N.

If the parent-teacher association is a strong organization, because of its connection with the school and because its members are from all social and religious groups, it is probably the best integrated organization that can be found. If it is selected, ask to meet with its members and discuss with them the forming of a health committee as part of their organization. Prior to the meeting, the director can submit a list of those selected and ask if the organization approve that these appointments be made. This gives to them prestige of having been chosen by a county health department and predisposes them to co-operating attitudes. The chairman of these committees should meet with the director quarterly. These meetings may occur in each supervisor's beat, or in some other convenient division of the county.

In larger towns where there are several outstanding organizations, small health committees should be formed in each one according to the general method outlined. However, each organization will have probably a major health program, such as the Rotary Club or Masons have for the crippled children. Use these established interests as assets and integrate them into a harmonious whole. See where duplication occurs and assist in eliminating it—guide organization without any chief interest into sponsoring certain phases of public health that may be neglected.

The chairman of these small health committees should regularly meet and be kept in touch with the problems of the health department. This inner circle is one that should have greatest help—for they return to their organizations and pass on to them what has been given them.

Very serious consideration should be given to the program for these meetings. Busy people should not give their time unless something worth while is given to them. The quarterly report of the department with its confusing array of statistics should be interpreted to them, as what has just happened in THIS county from a health point of view. Make them see figures as they relate to individual cases with whom some of them may already be familiar.

Take your committee into your confidence. Explain what disease and death rates mean in relation to the nation, state, and county. Let them, as a county, find out where they stand. You will find that each section of the county has problems that may not occur in others. You may have a county with low marshy land and also hilly sections. Some portions will have clay soil and others sandy. Some parts will have satisfactory milk ordinances in force, while others will not. In town you will have sewerage systems and outside the problem of small town or private sewerage disposal. Consider their problems separately with them, and get a community pull behind a project. None of us like too much theory nor abstract ideas. We want something practical that we can go out and discuss in after-church groups, or about a store counter. From these facts consider what the chief health needs are and how these needs are being met. If curtailment of any service must occur, decide with what correlated groups the division of responsibility can be made. Your committee will have excellent ideas about this and they will be able far better than the health department to make these adjustments possible and to achieve the desired end. Do not make the mistake of detailing to them simple things, but develop their sense of responsibility and then expect them to be responsible. Never fail to give them credit for their accomplishments.

Be prepared with an agenda for the regular meeting of the chairmen. Have copies of selected portions of the quarterly report with a narrative section ready for distribution to each one. As they become familiar with the ideas incorporated in it, point out increasing rates, possibly because of less funds available for the purchase of immunizing agents. Discuss the availability of sanatorium care as paid for through county funds against the cost and effectiveness of the Burr cottage. Discuss nutrition in terms of school lunches and the need of pure milk for these malnourished children. Hookworm surveys can be tied up with sanitation. Topics would be limitless and the interest and disseminated information would be difficult to gauge. Some of these meeting should be county-wide and it would be wise to have all chairmen bring in a brief report of their most outstanding health accomplishment of the past year. Much is gained through this interchange of ideas and better knewledge of the problems of each other. This should be a social meeting and ease and friendliness best come about over a cup of tea and a bit of cake.

These broader aspects of how committees can function have led me astray from my topic, but it was because of the preconceived ideas of the assistance that lay committees usually give. We think of them generally in terms of school service. This service is often so well developed that with reorganization of our part of it, others can assume the major responsibility for it. In one county in the State, certain county needs were discussed with the heads of the teaching group. Their clear vision recognized that in past years the schools had received the major portion of the service of the health department. Because it had been so excellently developed, they were willing to assume certain duties that freed the department so that neglected phases of the work could be developed in better balance. We can hardly call this professional group of teachers, lay helpers and yet they are the most steady and constant health deputies that we have. Our interests and aims for the children run along harmoniously and I believe we all appreciate their splendid cooperation.

Wherever it is feasible, the rural health committees should develop health conference centers and assist in their equipment, so that they may be prepared to care for all types of conferences or examinations held by the health department. Sometimes they can be located in a school or in other public places. In doing this they should understand the value of conference methods and how group teaching releases the nurse for further activities. In these centers, they can give valued assistance along the lines with which we are already familiar:

1. Getting the centers ready for the conference.
2. Transporting children and mothers.
3. Assisting with records.
4. Weighing and measuring.
5. A specially trained person can assist in the screening of testing vision and hearing for the nurse.
6. Getting the children ready for examinations.
8. Filling in records for the physician. Someone should be selected for this who will appreciate that these records are confidential.
9. Making out home slips.
10. Selecting pamphlets that interpret the findings of the physician to the home group.

This service frees the nurse that she may be everywhere, observing and assisting in the tests that are being made, and giving personal information regarding the child undergoing examination. Checking up on home slips, that they are accurate, and finally, discussing the condition of the child with the mother.

A newer service for the health committee following a conference is the evaluation of the service given at the conference. Therefore, they must know the number of corrections of defects made, the changed regime of a child's living habits. This means home visiting usually with the nurse until the worker is better informed and as a result of this, activities start in communities to bring about the changes that need to be accomplished. Through these interested women, we would soon have flung out over the county a network that would reach each prenatal or neglect infant or child and get them under proper care.

Sometimes box suppers and quilting bees have become responsible for the purchasing of glasses for one youngster, or a tonsillectomy for another. If we make community health a community responsibility its possible achievements cannot be foretold.

If we can make these committee people feel that the family problem in their midst, is a community problem and that the nurse and doctor are there to assist, we have started on the right road. They are responsible for their common health and we should remain in the background.

Going to our card index or notebook, we hunt thru it, finding out what special interests we have tabulated and from this comes a vast amount of aid.

Here we have one who has studied typing and can get no work. When we ask her if she is losing her skill and speed, we often find she is worried over just that thing. She will be a rare person if she will not help us with some of our clerical work and indirectly keep herself in form. She can be taught mimeographing and can assist in preparing the quarterly reports for the central health committee. Others may want to keep up in dictation. Requests sent in to graduates of night school often bring results.

Some who are clever with their hands can take charge of supplies for the health centers and be responsible for a loan closet.

Occasionally, we may find some one who has a special talent for writing who may prepare excellent articles with local interest from authentic information. They also would be responsible for publishing news items concerning the activities of their own committees.

Those who can entertain successfully in their own home will be interested in planning exhibits, programs, and entertainments for their organization. The objectives and methods of handling this have already been outlined in Dr. Milne's paper.

When we get people working along the line of their chief interest, or ability, they will be able to accomplish things we could never do. Several surveys are under consideration and certain of these women will be admirably fitted to assist in these. Not long ago, the conversation of two farmers was overheard—one said "That sanitary inspector has been out to my house talking about those pit toilets. Do you know he had my wife all worked up over it. She says we must have one right away." After a pause, he added "It took me two days to quiet her down; but you know, when these women get started on a thing it usually goes through."

Add gradually to your card index another section containing the names of the people whom the health department has outstandingly helped. I recall a story of a health officer who said he had discovered that a child of a lawyer needed glasses badly. The father looked up the director and expressed his appreciation to him and then the father added, "why the little fellow has always been that way and we didn't know he couldn't see." When that officer has difficulites, he goes to that man and things mysteriously happen. We have all had experiences like that and we forget about them. But in time of stress such information could be turned over to your health committees and the services we gave, without thought, could come back bearing multiplied results—not to us, but for increased opportunity for service to others.

CONCLUSION

I think the discussion has brought out very interestingly, how organizations definitely assist the health department.

There are one or two points that have come to my attention during this conference that we might add to the special function of the lay workers.

We are trying to make greater use of the vital statistics relating to maternal deaths, still births, and births. In the fulltime county health departments, vital statistics are reported for the preceding month by the fifteenth of the following month. We are eager to reach the families in which maternal deaths, stillbirths, and births have occurred earlier than the report comes in. It would be very valuable service if lay workers could bring this information to us as soon as cases are reported, to the registrars.

In our work with the negroes we have no more valuable assistance than that given to us by the midwives. Mississippi should be justly proud of the midwives.

The past year has been one of great financial anxiety for county health officers. It has been necessary for them, and often for the members of the staff, to go out and use every effort to obtain proper appropriation. This has been necessary and yet this disturbed, uncertain state of mind, actual time consumed in these efforts have interrupted the continuity of the services given to the county. It is not fitting nor dignified that last hour conversions should have to be effected. If, however, health committees were established and informed, to carrying on a whole year round service, the greater part of this difficulty would be cared for by them, for organized public opinion is powerful, and public health is vital to public welfare.

Dr. Freeman so aptly said, "Time is the most important commodity of the health department and we should safeguard it—give them something to do. Manufacture it, if necessary."

DISCUSSION OF MISS STOLL'S PAPER

By T. Paul Haney, Jr., M. D.

In Pike County we have 28 organized groups —26 in McComb, one in Magnolia, and one in Jones Community.

McComb has a population of 10,653. All of the 26 organized groups are being used for promotion of community health. This includes the missionary societies and sub-divisions of the churches, the Rotary Club, the Book Club, the Literary Club, the Parent-Teacher Associations, one Mothers' Club, Boy Scouts, Girl Reserves, and the class in High School composed of 42 pupils.

The Parent-Teacher Associations of the different schools, including the Mothers' Club, are sponsoring the milk program in the city schools. The missionary societies are co-operating with the parent-teacher associations in paying for milk for children who are unable to buy milk. One missionary society is taking care of a tuberculosis patient for us in supplying food, medicines, and also made provision and preparations to send her to Magee for an examination. Another missionary society supplied a baby layette for demonstration purposes. The parent-teacher associations are also sponsoring a campaign against diphtheria.

A Mother's Club is meeting monthly. This club is in the mill district of McComb and was organized by one of the nurses in an effort to better health in that district. Thirteen mothers were present at the organization meeting of the club. They took as their project to have all infants and preschool children immunized against diphtheria and to provide transportation for those who had no way to come to the health office for physical examination. They also hope to provide a playground and supervised play for the children. There has been an increased attendance at each meeting of this club, and all of the women seem very much interested in it.

The Rotary Club endorses any program introduced by the health department.

The Senior Class of the McComb High School left as their class memorial a tuberculosis cottage, which is being occupied by one of the high school students. To get money for this cottage the senior class put on a stunt night and made $48.00 which paid for the cottage.

On September 22, a Health Council was organized in Magnolia. This council is composed of one member from each organized group of women in Magnolia. Magnolia has a population of 1500 and is located in the southern part of the county. There is a large cotton mill located there. In the mill district we had two women who were in charge of the Nararene Church. They were very helpful in the health work, providing transportation and getting infants and preschool children into the health center for physical examinations and immunizations, and in getting defects corrected. The

Health Council is composed of six members. The activities of the Pike County Health Department were outlined at the first meeting. A number of possible projects were submitted to this council and out of the number they selected four to work on for the following year.

1. To secure better offices for the health center in Magnolia.
2. To furnish a baby layette for demonstration purposes in the Magnolia office.
3. To get prenatal cases, infants and preschool children into the health center for physical examination.
4. To put milk in the grammar school in cooperation with the P. T. A.

All of these projects are well under way.

A Health Council was organized in Jones Community one month ago. Jones is located in the east central part of Pike County and has a population of ---- ---- -- The activities of the health department were outlined to this council. The council is composed of six members, leaders of the community. They took as their first project an orthopedic correction—a child who has double club feet. For their second project they are to study the needs of their own community. They are urging that all known positive cases be treated, and that all suspects be tested and take treatment, if necessary.

The Pike County Tuberculosis Association has been very co-operative. They donated the first Tuberculosis Cottage we had in the county. They have also furnished milk and supplies, such as medicines, etc. for tuberculosis cases throughout the county.

The Red Cross bought material to make capes to be used in physical examinations and had the Parent Teacher Associations of McComb make these capes.

How I Would Carry On A Tuberculosis Campaign

BY EVELYN KAMPER
Age 15, 11th Grade

If, given an adequate supply of money and help, and the choice of a position to benefit humanity I could not step into the role of the President of a charity organization or superintendent of a foundling home. No, I would settle myself comfortably in front of an elegantly equipped desk and elect myself Director of a Tuberculosis Campaign. Then having achieved this position, I would go to work earnestly and fullheartedly to carry out this campaign to the best of my ability. Under my authority I would place several colleagues and together (it is much too big a job for one) we would fight this menace to a finish. Oh, yes, it can be done!

In mapping out my campaign, after much thought, I have placed first—"Have all physicians report cases to the health department." This not only prevents spreading of disease but brings about co-operation between the health officers and the private physicians. Second—"Have a public health nurse visit all cases." By this members of the family and contacts can be reported. Third—"See that a health officer tests all contacts for tuberculosis." In this way those found with the disease can be put under early treatment and the disease "nipped in the bud." Now all of our prevention work is done. But, you say, those who already have it—. They must be cured.

And we turn to phase Number two of our work. First, let us put the patient in a tuberculosis cottage. Next have the family physician outline medical treatment. See that a public health nurse visits the patient regularly and have some provision made for proper food which should include plenty of milk.

Last, but by no means least, we must teach the patient that plenty of rest, fresh air, good nourishing food, and freedom from worry are the things necessary to cure tuberculosis.

The Present and Future Significance of the Findings and Recommendations of the Committee on the

Costs of Medical Care—From the Physician's Point of View*

BY DR. LEWELLYS F. BARKER

As a physician, I feel that both the public and the medical profession should be very grateful to this Committee, first, for its careful analysis of the whole situation; and, second, for pointing out the paths that it regards as most promising for better things in the future.

No one is more proud than I am of what the medical profession has done in this country in the way of medical research, in the way of medical education, and in the development of the possibilities of medical practice, but no one knows better that the medical profession that there are still great inadequacies of medical care and great difficulties in the distribution of medical care and in the payment of the costs of medical care.

There is something wrong in the country where provision is not made for the 80 per cent of the people whose incomes are insufficent to supply them with proper medical care during serious illness. Of course, the medical profession does the best it can and the public is doing the best it can, as it thinks, but there is something wrong in an organization that does not make definite provision for the care

*Delivered at the National Conference on the Costs of Medical Care, New York Academy of Medicine, Nov. 29, 1932.

of serious illness among 80 per cent of our people.

The medical men all agree that patients should have competent doctors, that patients should have access to good facilities, that the personal relations between doctors and patients should be maintained, and that the costs of medical care should be within the reach in some way or other of everyone who needs the care; in other words, the costs must be in some way distributed so that every patient who needs care can have it.

In this report all kinds of efforts that have been made have been carefully summarized. There was a large variety described, some of them excellent methods; some of them are very defective; some of the methods of medical care are actually pernicious, as we medical men know perhaps better than the public knows. The Committee has recommended progress by a process of evolution rather than by revolutionary change and, as a medical man, that appeals to me as a wise recommendation.

In the discussion of agencies and distribution of costs, the Committee has avoided, on the one hand, the laissez faire attitude of doing nothing and, on the other, any sudden and rash venture into dangerous areas. It has recommended experimentation especially by local groups.

As a doctor, it sems to me that if the recommendations of the Committee could be widely adopted, many of our present problems would be definitely solved; that there could be adequate curative and preventive medicines applied for all income classes; that ways of distributing, co-ordinating, and financing the costs of these services would be determined; the medical profession would be properly safeguarded and more adequately remunerated than now; the danger of degradation and demoralization of the indigent would be lessened, and the bugbear of a huge and dangerous bureaucracy would lose its terrors.

This Committee includes physicians and surgeons, social workers, public health workers, administrators, government officials, and representatives of the public. As has been said by several of the speakers, it is inconceivable that there could have been unanimity of opinion in such a group, undesirable that there should be unanimity of opinion. How could there be at this stage of development? Conclusions cannot be equally acceptable to all because of such varied interests and such different viewpoints represented on the Committee. The two things that are most criticized are the recommendations regarding group service and group service and group purchase, and those are the two main recommendations of the Committee.

As a group service, there is great fear on the part of many in the medical profession that the domain of the individual doctor might be encroached upon, that doctors would come under lay control, and that the personal relations of doctors and patients would be interfered with. When it comes to group purchase, there you run up against one of the things that immediately excites the fear of state medicine on the one hand and of compulsory insurance on the other. This violent opposition, talk of Socialism, talk of Communism, as we have heard, result largely from the bad patterns of group purchase that were established at first in Europe when the attempts were made to distribute costs. It is no wonder that those bad patterns should be feared; they should be, and they should be avoided.

The Committee foresaw a good many of these objections and in the majority report it laid great stress, as does the principal minority report, on the complete separation in any insurance principle of the costs of medical care from the cash benefits that go for loss of wages due to illness. By that single recommendation the Committee removed one of the chief apples of discord. If those two things could be kept absolutely separate in any general provision by distributing cost, you would avoid a great deal of trouble, for the principle of insurance was introduced in the first place not to provide medical care at all but for the relief of poverty. Medical care was tacked on as secondary consideration and in most of the European patterns the two were kept together and there was a continual clash between the physicians on the one hand and the social workers on the other. There always will be clash between social workers and politicians on the one hand and doctors on the other if those two things go together, cash benefits and care of illness; but even if cash benefits are kept entirely separate from the medical care, there are enough problems connected with insurance. Dr. Van Etten has referred to some of them.

In European countries the mortality rate has not decreased under this insurance system. In the third place, the average duration of illness has increased under the insurance system; and, in the fourth place, some wholly new diseases, namely, the compensation neuroses, have come as a result apparently of these laws.

However, bad as it has been in Europe, bad as some of their patterns established have been, the average care of the sick is better than it was before insurance was introduced. The average income of the doctors concerned is larger than it was before; and, a third point, no country that has resorted to the principle of insurance has given it up. Those three things must be remembered.

The doctors on your Committee are members of the American Medical Association and they feel a great responsibility both to the public and to the medical profession, but we must not forget that doctors in general have a very individualistic attitude. They fear any mass action, any mechanization of medicine, and they are right, quite right. They realize, and rightly, the great importance of the personal relationship of doctor and. patient, and they are very likely to react with violent opposition to any innovation on account of their conservative, individualistic attitude. They are afraid of innovation, very much afraid of it.

I want to warn my colleagues in the profession against too negative an attitude. This world is not static. This world is changing all the time. The medical profession must change with the rest of the world and keep pace with it. The negative attitude of our English and German confreres was very disastrous to the medical profession. That negative attitude did not prevent the development of health insurance in England and Germany. It put the doctors in a very false light. It excited public hostility against men whom the public were led to believe were acting from a selfish attitude rather than from a public spirited attitude; and, worst of all, the medical men lost their influence and leadership and had very little to say about the patterns of insurance that were established.

Recently medical men have waked up to that fact in Europe and have seen that some kind of insurance was inevitable, and helped to form new patterns of health insurance, tried to protect both the public and the profession and tried to keep the medical control of the purely professional aspects of the worker.

Shouldn't we in this country profit by those mistakes that were made in Europe? In my opinion forms of health insurance are bound to be tried out in this country. They should be tried out. We must watch them and try to direct them in the right way and discover what place, if any, health insurance has in the American program. Let the doctors lead in this and try to determine the policies and make them good, instead of bad, and in doing so the publications of this Committee will be very helpful to them, and if doctors take that attitude, instead of the other, negative attitude, we will keep the good will of the public, avoid hostility, and maintain the dignity and ideals of the profession.

I welcome the minority reports. I welcome the statement of Mr. Hamilton. It is well to have those things put down, to see what groups and persons are thinking. I welcome the criticism of group practice, of the community center, of voluntary insurance. I see the danger of new evils and they have vividly portrayed them in their reports. Their emphasis on the county society method is well worth listening to. What the Milwaukee County Society has done might be imitated in other places. I should like to see that method tried elsewhere, but these minority reports and single statements ought to be very helpful. They ought to make everybody act more cautiously and more warily. To be forewarned about possible evils and dangers is to be forearmed against them.

Aside, wholly, from these differences of opinion, there are a host of opportunities for action. These opportunities ought to be recognized promptly and acted upon all over this country. There should be community organizations to study and to take the lead in the work, possibly some state organizations; no harm in a general national organization that will help and advise.

This Committee on the Costs of Medical Care goes out of existence this year. That must not be forgotten. What hard work they have done! What noble contributions they have made! The fact-finding alone is worth the cost of the whole Committee. The advice they have given has been very carefully considered. Surely it is up to the leaders of thought and action in this country to pay serious attention to the report of the Committee and to do what they can to bring about reforms.

I think we owe a great debt to the Director, to the administrative staff, to the research staff, and the foundations who have made the study possible, and I believe that the publication of this report today marks the beginning of a new epoch in American history.

The Minority Reports of the Committee On The Costs of Medical Care*

BY NATHAN B. VAN ETTEN, M.D.

I have the honor, Mr. Chairman, to comment briefly upon some divergent visions of a few members of our Committee upon the solution of the problems of "The delivery of adequate scientific medical service to all of the people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life." All of the studies were pointed at this target or at sources of reflected light which might illuminate it.

The work of the Committee carried on by an exceptionally able director and staff, is monumental and we learned much about adequacy, costs, and distribution, and the details of many experiments supported by masses of statistics which were delivered so rapidly and so continuously that there as some inevitable indigestion when we suddenly changed into gentlemen of the jury who must weigh evidence and recommend cures for a faulty social operation.

All concurred in praise of the diligence, skill, and logical presentment of the findings and in most of the interpretations. All tried to harmonize themselves into unanimity with such success that upon only a few fundamentals or implications are there dissentient opinions. One believes that the report has missed the target; another that the recommendations have fallen short; and others believe that the mark has been overshot by excursions into Utopian idealism.

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*Delivered at the National Conference on the Costs of Medical Care, New York Academy of Medicine, November 29, 1932.

The objections of the minority composed of eight physicians and a clergyman, are to the recommendations in "Organization of Medical Services." The minority report of two leaders in the national dental organization is in general accord with the first minority, but in agreement with the majority upon "Group Payment."

The minorities desire changes in medical education, urging—in addition to the present scheme which seems to qualify sufficiently for the care of 80 per cent of the ills of mankind—emphasis upon the development of clinicians and added accent upon the importance of teaching disease prevention. They wish that mere prudential ethics may be strengthened by spiritual ethics and that only those possessing high character and high educational qualifications be admitted to the professions.

Premature specialization and overspecialization will be cured by the special societies acting within themselves, and the evolution of dentistry into whatever its destiny as a department of medicine will be determined by the concerted action of a well organized profession.

The minorities object to contract practice whenever it operates in restraint of opportunity for all competent and reputable physicians in the community, or results in unfair competition or furnishes inferior medical services. The same objections are made to pay clinics when operated for profit by laymen as "exploitation of the public and of the medical profession" through inferior quality of service with no lessening of the costs of medical care to the patient who must add operative charges to the normal or average fee prevailing in the community.

The minority claims overemphasis upon the virtue of group clinics and cites in opposition the large number of groups treating patients under workmen's compensation laws, in active competition one with another, "soliciting patients through paid agents." Many of these groups are under lay control—keeping down costs by employing physicians of low ability, commercializing medical practice, lowering ethical standards, demoralizing physicians into undignified advertising in factories, reminiscent of the old lavatory posters, leading physicians to compete for practice by buying cases for one-third or one-half of their fees and, in collusion with agents prolonging treatments far

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beyond reasonable limits and padding their bills, as developed publicly by the Seabury investigation this year, and not denied.

The minority objects to the influence of this Committee being used in the promotion of new forms of political bureaucracy, feeling that the unsatisfactory operation of the forms of compulsory sickness insurance now carried on in forty-four states under workmen's compensation laws has degenerated into racketeering in our large cities and should be corrected by legislative action which should lead to real revision of these operations and carry them into the administrative hands of those who represent the higher medical honor and higher medical intelligence of the community.

Here the hospital or medical center may furnish the place and the skilled staff service all of which should be amply paid for.

No arguments demonstrate a Quality of service, in countries where compulsory health insurance prevails, which is superior to the admittedly inadequate and badly distributed service now operating in the United States. Quoting from Simons and Sinai:

"Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days and average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from seven to nine days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, and has practically doubled in both countries since the installation of insurance."

The minority report states:

"It ought to be remembered that compulsory insurance will necessarily be subject to political control and that such control will inevitably destroy professional morale and ideals in medicine. Since a qualified and untrammelled medical profession is the only agency through which scientific medicine can be applied for the benefit of the people, it follows that any plan which destroys professional morale will bring disaster to the public."

Quoting again from Simons and Sinai:

"While the statment might be disputed by insurance societies, a comparative study of many insurance systems seems to justify the conclusion that the evils of insurance decrease in proportion to the degree that responsibilities, with accompanying powers and duties, are intrusted to the medical professions."

This statement is both a challenge to the medical profession and a warning to those who, without proper consideration of that profession, are willing to recommend the adoption of various new plans for the care of the sick.

The minority feels that our Government has strained paternalism far beyond moral justifi-

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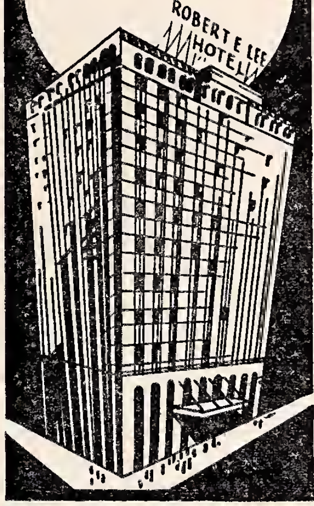

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cation in the extension of veterans' hospitals and in the hospitalization of veterans with non-service disability and has spent the people's money with inexcusable recklessness. This sorry exhibition should make us all shy of Government invasion into control of any phase of medical practice except, of course, in the field of public health and in the institutional care of those unemployable wards of the State—the tuberculous, the insane, the feeble-minded, or the hopelessly crippled.

The minority objects to the large medical center as projected by the majority on the ground of exclusion of many physicians, of oppressive competition, of big business technique erecting machinery which eliminates personality and destroys personal relations by factory forms. Mere bigness is often a liability. The city of New York is so big that real community interest and civic pride are crushed and the citizen taxpayers are too dumb to protest against a self-perpetuating political machine which rules them.

The minority recognizes the practicability of centering medical service in small places where there are only one or two hospitals and where all of the physicians of the community are permitted to use all of the facilities of the hospitals in a true community spirit, the institution being supported by taxation or by gifts. My personal opinion is that if all hospitals were open to all reputable physicians (not merely the laboratory facilities, but beds as well) many of the problems of public service would be solved. I had always believed this to be administratively impossible until it was positively demonstrated to run smoothly in a very large hospital. Places where there are no hospitals and few physicians, dentists, or nurses, must be served in other ways with the entire health service of the county concentrated upon ways of distributing urban surpluses into neglected fields.

The minority favors continued study of group practice, co-ordination of the medical, dental, pharmaceutical, hospital, and nursing professions, the study of the application of the insurance principle to the accumulation of reserves, and to the assurance of solvency of institutions.

The "challenge of the future" in the majority report is a vigorous, stimulating statement that the work is not only not finished but only just begun, and that continuous widespread efforts must be carried on through all medical, education, and all other agencies whose interest leads them earnestly to desire the prevention of disease and the general health of our people.

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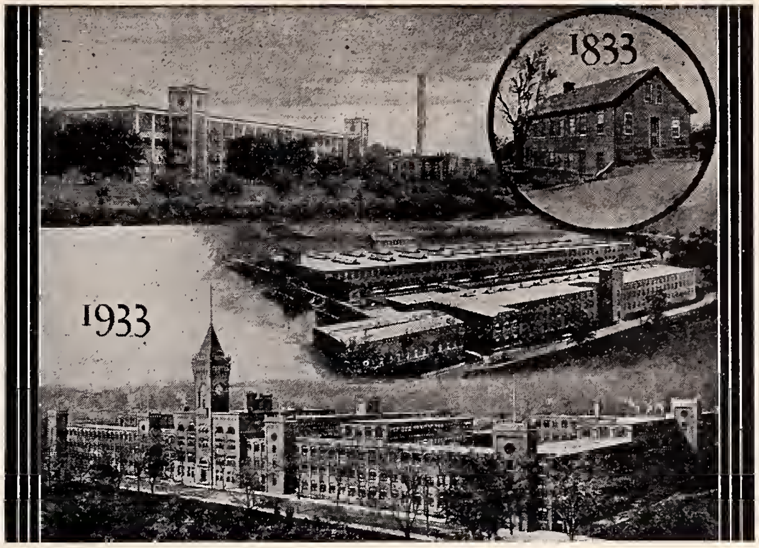

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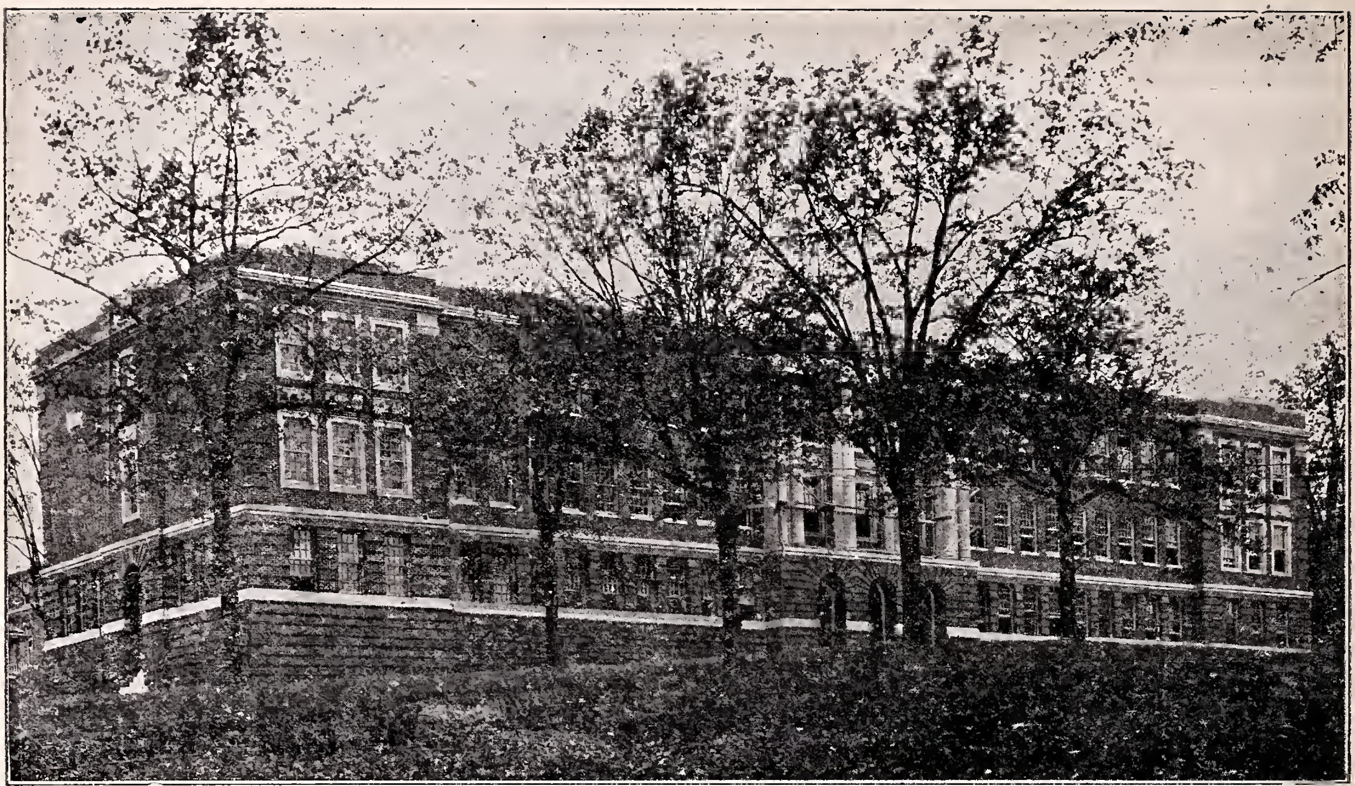

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Exceptional faculty of experts trained in the best colleges, universities, and conservatories of America and Europe. Special advantages in piano, pipe organ, violin, voice culture, expression, home economics, art.

Entrance only by graduation from accredited high school or by examination. We have no preparatory department.

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THE MISSISSIPPI DOCTOR

VOL. 10. BOONEVILLE, MISSISSIPPI, FEBRUARY, 1933 NO. 9

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DR. PERCY W. TOOMBS

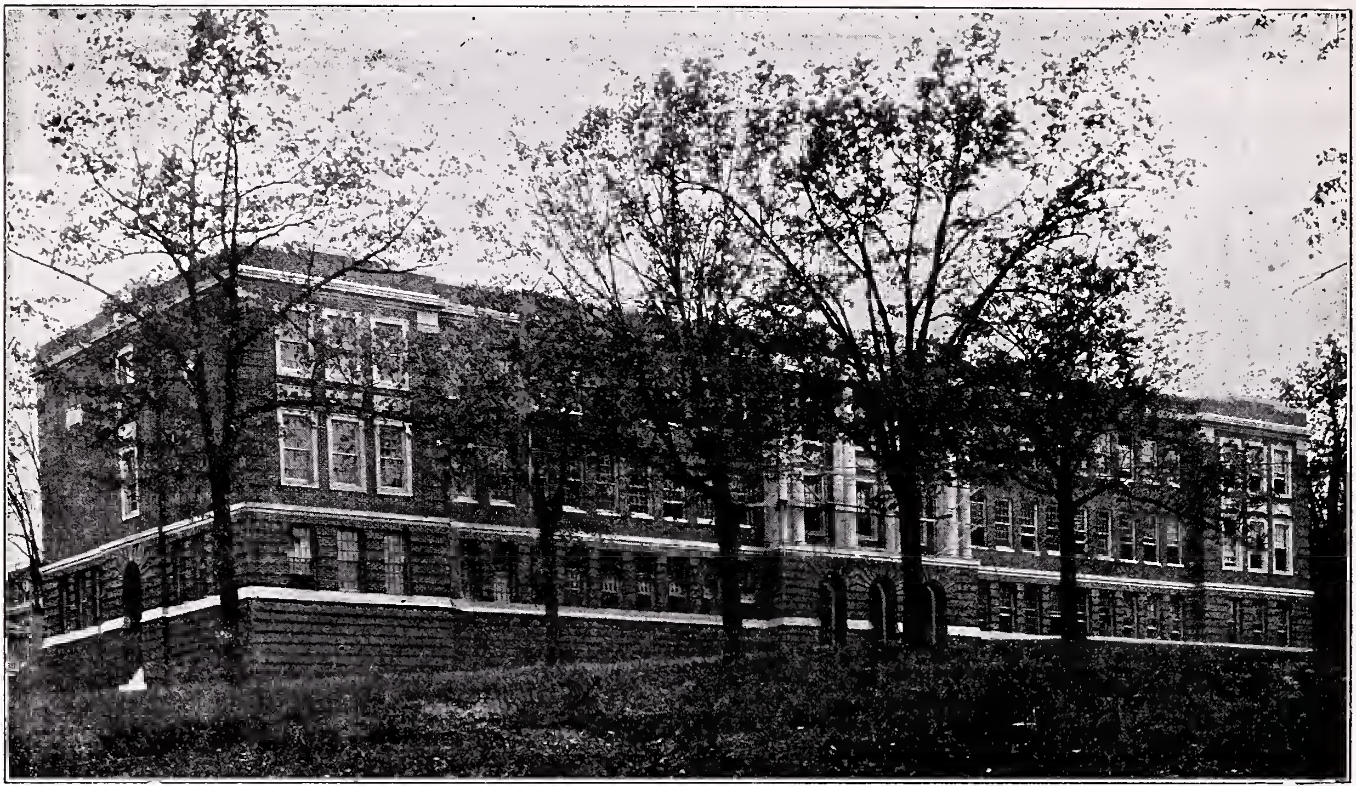
To the cherished memory of Dr. Percy W. Toombs we dedicate this issue of The Mississippi Doctor—

A native Mississippian who won the proud admiration of our entire medical profession,

Immaculate in appearance, thorough and advanced in the art of his specialty, versatile and cultured, and possessing a professional mind, a medical soul and a missionary heart,

A pioneer, a tireless worker, and one of the best loved obstetricians of our nation,

"And when he fell in whirlwind, he went down
As when a lordly cedar, green with boughs,
Goes down with a great shout upon the hills,
And leaves a lonesome place against the sky."



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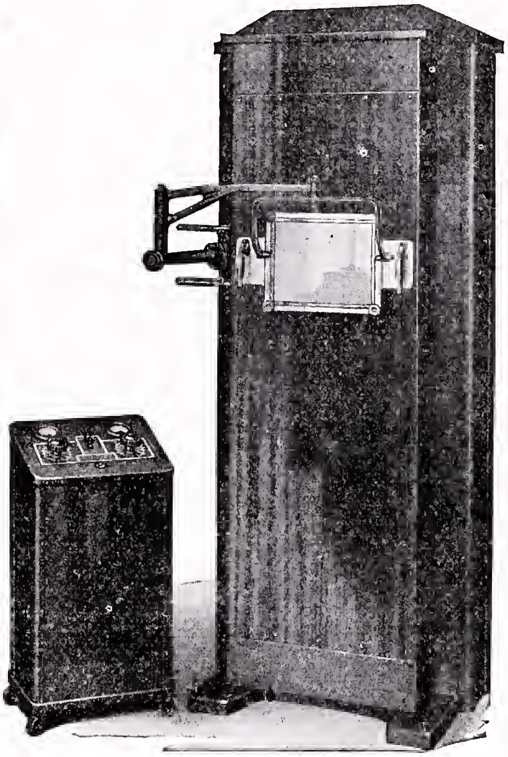

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THE MISSISSIPPI DOCTOR

OFFICIAL ORGAN OF THE NORTHEAST MISSISSIPPI 13-COUNTY MEDICAL SOCIETY
—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager
MRS. W. H. ANDERSON, Associate Editor

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It is now said that rheumatism is twenty times as prevalent among the poor. Don't you feel your "jints" aching?

On March 21st our society will meet at Macon. Macon is in the lower part of the district. It is a nice town. It is a nice town in which to meet. Let us all go down and get a fraternal handshake and listen to a good program. It will be near enough for Meridian to come up and "partake" of some of our schooling.

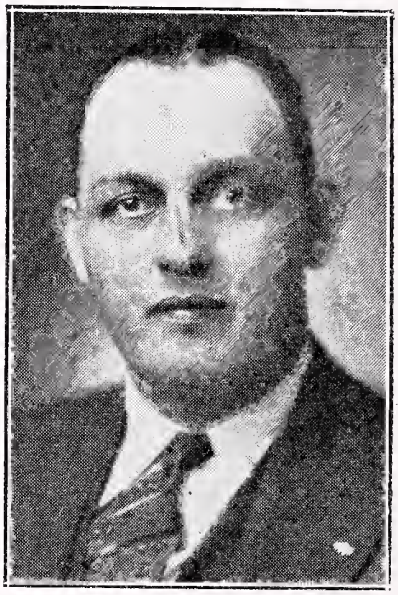
The Mid-South Post Graduate Medical Assembly is the best you can possible attend in this section. It has but few equals and superiors in the United States. You can afford to make a sacrifice to attend. It will be good for you and still better perhaps for your clientele. Medical science is growing just like broom sedge. You have to keep going to keep up. We should rejoice and be exceedingly glad that we are so near to its annual meeting place.

We wish you would subscribe for The Mississippi Doctor. It is a journal with a mission. Take advantage of our "depression price," one dollar for one year, twelve issues.

Have you paid your dues to your local society? If you have not you should manage it some way some how. You owe some of your time and some of your means to organized medicine. Your local society is your mother in the medical profession. If you fail to attend your local meetings and fail to pay your dues, you could hardly be depended upon to give time and love and financial support to your mother. It is not a matter of convenience, it is a grave duty that you should grit your teeth and meet. Your medical dues is the oil that keeps the machinery of organized medicine turning. Any country boy can get to school, or could, on a nice bright day, but the student that you might watch for future success, will be a little ahead of time on a rainy bad morning. In flush times almost any man will pay his dues rather than to be bothered. But in times like this if you have the extra ordinary stuff inside, you will just pay any way. Let us pay as promptly as we can. Dr. Acker gives us lots of time without any pay. We should appreciate it. Ingratitude will impoverish the soul of any man. We should have pride. Since Dr. Acker is our state president we should give him a hundred percent membership through society pride. It will pay you to pay your dues. Don't forsake the society, don't neglect the mother of your profession, your local society. Pay your dues.

The Ole Miss Medical Department is still on probation. All of our other state colleges are back in regular standing. The medical department should be. It has rendered too much service in the past and it has too much work to do, to be destroyed at this time. Ole Miss has graduated about four hundred students in the two year medical course. About ninety-five percent of them have gone ahead and graduated from other schools. One third of this number are now practicing in Mississippi. Graduates of the Ole Miss Medical school have stood high in scholarship. They have made good in practice. They compare favorably with any other students in the last two years and on state medical examinations. In practice they are second to none. They are taught to work at Ole Miss. They are taught to win by merit. Our boys can go here cheaper. It is no time to destroy a school because it can not build a certain building, or maintain certain equipment that tickles the fancy of some theoretical extremist. The spirit of a school counts. The type of young man selected is of the greatest importance. The school that teaches a young man to work in a practical way, the school who takes into consideration the profession mind, the medical soul and the missionary heart of the student is needed at this time. This is the Ole Miss Medical School. The medical profession is swamped with specialists now, about one in four when one in ten is enough. Some of our leaders a few years ago wanted to take short cuts to put out more doctors. We showed the folly of it then, tried to. Some of this type of leaders now think that you have to have a building with a certain number of stories and a pile of laboratory equipment that is exactly like those used in Chicago or New York before you can learn. Too much equipment is leading to weakness and inefficiency in many ways. The students are taught in terms of expensive hospitals, internes, nurses, laboratories etc. They can't do practice in the small town or rural community, or won't do it, hence the country folk suffer for ordinary everyday medical service. It is not fair for the Ole Miss Medical Department to be destroyed. The medical profession of Mississippi must not permit it. Speak out in the meeting. Write The Mississippi Doctor what you think.

The committee on the Cost of Medical Care has done some good work. There is much more to do. We thank the committee for the service it has rendered. The problem is not yet solved. If the medical profession does its full duty, we will not have state medicine. The rank and file of the profession must have more money and the masses must have better service for less money. This can be accomplished through th means of the well ordered clinic and the small hospital out on the firing line hard by the people. We must strike an average, cut off half of our specialists and raise the batting average of the practitioner. We need to revise our medical schools to teach practical preventive medicine and surgery.



Dr. L. H. McDaniel, our 1933 head of the Mid-South Medical Assembly, though a practising physician of Tyronza, Arkansas for the past ten years, hails from his native city of Covington, Tenn. He is the youngest president the association has ever had, or far as we know, but holds an enviable succession of rises both in his social and professional career. After being graduated from Erskine College, Due West, S. C., he came to Memphis to get his degree in medicine from the University of Tennessee College of Medicine, afterward serving an interneship at the Baptist Memorial Hospital. A member of the Phi Chi medical fraternity; a Knight Templar, Jonesboro, Ark., a member of the Scottish Rite, Little Rock, Ark.; a member of the Shrine, Sahara Temple, Pine Bluff, Ark.; he in addition to his professional interests holds the presidency of the Poinsett County and Tyronza Board of Education, is medical adviser for the Poinsett Red Cross, makes radio addresses of political, civic and educational nature and is well-known in Arkansas medical circles for his addresses and original work on "Pellegra."

Dr. McDaniels is quite easy in manner, but he is active and aggressive in leadership. He has worked hard for the success of the meeting. He will preside with grace and efficiency. He makes the following statement.

The Program Committee has exerted every effort to make the 1933 meeting of the Mid-South Post Graduate Medical Assembly, formerly known as the Tri-States Medical Association, the banner meeting of its history. In this day of depression, when a dollar and the value of a dollar looms tremendously before us all, we hear everywhere the clarion call of economy and elimination of the non-essentials and superfluous. With that idea in mind, the program committee has eliminated the Banquet this year along with other unnecessary expenses so in spite of the distressing economic conditions no physician within a radius of two hundred and fifty miles of Memphis is justified in missing this meeting.

The speakers, this year, are the leading medical authorities of the country so an instructive as well as a pleasant four days is in store for every physician who attends this assembly.

L. H. McDANIEL, M.D.
President.

The above is a likness of Dr. A. B. Dancy of Jackson, Tenn., the incoming President of the Mid-South Post Graduate Assembly. He stands high in the medical profession of the state of Tennessee. He is not only well versed in his profession, but he has culture and refinement based on a broad education. He is graceful and easy of manner. He will make a fine presiding officer. He also has vision for the association.

Percy W. Toombs

A tower is fallen, a star is set! Alas! Alas! for Celin.

These word of lamentation from the old Moorish ballad must have risen to many lips when the medical profession learned that Percy W. Toombs was dead. Too, the thought must have been more instant and the cry of sorrow more expressed among the vast laity of motherhood whose golden thread of personal feeling vindicated his real greatness—service to mankind.

Dr. Toombs was a native of Mississippi, born in Greenville in 1880, the son of Reuben Saunders and Fannie Toombs. After receiving his public school education in Greenville, he was graduated at the age of twenty from Georgetown College, Georgetown, Ky., in 1901, and was awarded an LL.D Degree from the same institution in 1926. He received his M.D. Degree from Tulane University in 1905, and during his final year there he delivered the Founder's Day oration, a coveted honor—the only student in the history of Tulane to be so honored. The following year he began the practice of medicine in Greenville, and for the next two years assumed the additional offices of district surgeon for the Yazoo & Mississippi Valley and the Southern Railroads, and served as president of the Greenville Board of Health.

Moving to Memphis in 1907 he taught physiology at the College of Physicians and Surgeons (now the College of Medicine, University of Tennessee) until 1909, when he became professor of obstetrics and obstetrician-in-chief of Baptist and General Hospitals, which posts he held until his death. From 1908 until 1916 he was district surgeon of the Illinois Central Railroad.

In 1915 Dr. Toombs married Miss Amy Randolph Morton, of Memphis, a woman of high intellectual attainment and charm, and a helpmate suited in ideals and understanding to his greatness.

In 1923 Dr. Toombs began a campaign for a separate and distinct unit of General Hospital for the care of maternity cases. The Maternity Pavilion was erected the following year and stands as a lasting memorial to his efforts to achieve better obstetrical service for less fortunate women. A director since its erection, Dr. Toombs has led in the work for which the building was dedicated, giving pre-natal, natal and post-natal care to many whose lives might have been sacrificed upon the altar of maternity.

At the time of his death Dr. Toombs was President of the Central Association of Obstetricians and Gynecologists, President of the Memphis and Shelby County Medical Society, a fellow of the American Medical Association, a member of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, of which he was vice-president in 1929-1930; a member of the Tennessee State Medical Association, of the Academy of Science, of the American Editor's and Authors' Association, of the White House Conference Child Welfare Committee; an honorary fellow of the Kansas City Southwest Clinical Society; a member of the Episcopal Church, of the Phi Delta Theta literary and Phi Chi medical fraternities, a 23rd degree Mason, a Knight's Templar and a Shriner; is listed in Who's Who in America, in the History of Tennessee and the Mid-South and Its Builders.

Dr. Toombs was the author of more than fifty medical treatises and books, "The Romance of Surgery," which follows in this issue, being a brilliant article of research to whose pages the achievements of the author might well be added for the kaleidoscopic view future generations will take of the present. Besides occasional contributions to the daily press, he was a contributor to the Memphis Medical Monthly, American Journal of Obstetrics and Gynecology, Southern Medical Journal, Illinois State Medical Journal, Mississippi Medical Monthly, Alabama State Medical Journal, American Journal of Surgery and The Mississippi Doctor.

Dr. Toombs followed his father in choosing medicine, and throughout his academical career he evidenced a brilliant mind, being graduated from Georgetown College and Tulane alike with first honors. In 1914 he studied in the clinics of Berlin, Paris and London. Always an ardent worker to reduce America's maternal mortality, giving unstintingly of his time and skill to charity, and laboring untiringly through his writings and addresses throughout the country, he proved himself a true leader in the profession, which can but mourn the loss of one of its greatest who was cut down in the middle of his career.

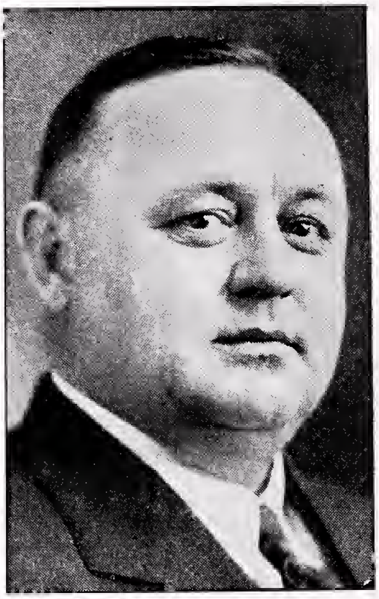
We would not approach Percy W. Toombs along the beaten paths of eulogy, for, though his field in the profession is as old as the sons of Eve, he made a definite advance over all the past. It has been said that medicine and civilization advance and regress together; that the position of woman is the index to that civilization, her position being gauged by the care given her at the birth of her child. To overthrow superstition, to protect motherhood from pain, to free childhood from sickness, to bring health to all mankind: these are the ends for which the saints and martyrs of medical science have worked and fought and died through the centuries. Percy W. Toombs' banner bore the same noble device, but he carried it to the pathless heights; he possessed the same intellectual courage and consummate love for humanity, but he prevailed further even than he knew.

So, to be cold and breathless is not the end of existence to a man whose lofty spirit has conceived, resolved and labored; for whose greatness nothing was too small; whose doctrine was a strenuous life; who treated difficulties as passing clouds overshadowing his garden —a garden which bloomed; whose high-erected thoughts were seated in the heart of courtesy; and whose fearless mind climbed to a crown.

These shall resist the empire of decay,
When time is o'er and worlds have passed away;
Cold in the dust the perished heart may lie,
But that which warmed it once can never die.

This is his life, and this his eulogy.

"In the death of Dr. Percy Toombs the Medical profession in Tennessee, as well as Mississippi and the entire South, has suffered a distinct loss. He was a leader in his line of work, giving his talents and time unselfishly to his large practice. Being born in Mississippi it is with special pride that we point to his many deeds and brilliant accomplishments. May there be consolation in the fact that because of his noble life and work many lives were born and saved."—Dr. J. M. Acker, Jr., Aberdeen, Miss., President Mississippi State Medical Association and Secretary Northeast Mississippi 13-County Medical Society.



The above is a likeness of Dr. F. L. McGahey, Calhoun City, Miss., president of the Northeast Miss. 13-County Medical Society. He is a native of Mississippi, Webster county. Here he received his preliminary education. He took his college work at Millsaps College. He received his medical degree from the University of Tennessee and spent two years as an interne in the General Hospital of Memphis. He served 13 months in the Medical Corps of the U. S. Army in France and Germany. He was discharged July 9, 1919 and he still holds a commission in reserve Corps as Captain. After his return from the army he practiced at Oakvale for eight years and has now been at Calhoun City for four years.

Dr. McGahey is a very active and able practitioner. He is a wide awake citizen who takes an active part in public affairs. He has a hearty handshake and a generous disposition. He goes about doing good cheerfully. He will make a splendid presiding officer. He will do his best to lead us forward. We extend to him our congratulations and offer him our right hand of co-operation. We will gladly follow his leadership.

We must spend and be spent in the endless battle for right against wrong.—Theodore Roosevelt.

The Romance of Surgery*

BY PERCY W. TOOMBS

Romance is largely a matter of perspective. The most commonplace landscape, viewed through the small end of an opera glass, has cast over it a certain glamor, a charm such as is exerted upon us by a Japanese miniature garden or a ship model. The events of our childhood have an interest in our adult years, quite out of proportion to their actual importance, so skilfully does the lens of memory perform its functions. In the same way we find romance in the early history of a race, a country, or even a manufacturing process. Only the present is prosaic; in "olden times" men were braver, women were fairer, and the sun shone more brightly than it does today.

So, in order to tell you something of the romance of surgery, I must go back to ancient times. If I were to detail the remarkable things which are being done this very day and hour that would be news, not romance, and you would feel cheated. In speaking of things medical it is customary to go back to Hippocrates, "the Father of Medicine." But as Hippocrates was a cultivated Greek, it is evident that romance began much earlier than his time. To track surgery to its original lair, we must go back to neolithic man.

The first evidence of human activity found wherever man has lived has always been the roughly triangular chipped flint—called in this country the "Indian arrowhead." And it was undoubtedly this same ancient, widely applicable tool which was employed to perform the first surgical operations. Garrison suggests that it was probably "some fragment unusually sharpened as to edge and point by accidental flaking, as in the obsidian knives of Peru. By means of these sharpened flints, or of fishes' teeth, blood was let, abscesses emptied, tissues scarified, skulls trephined, and, at a later period, ritual operations like circumcision were performed. . . .Trephining for epilepsy or other cerebral disorders goes back to prehistoric times, the finds showing that it was often done more than once upon the same person, the bits of skull excised being used as amulets. . . . Primitive man's wounds were dressed with moss or fresh leaves, ashes or natural balsams, and when poisoned, treated by sucking or cauterization. Cupping was performed by means of animals' horns. The revulsive effects of some accidental wound or hemorrhage, or the natural and periodic process of menstruation, suggested, no doubt, the advantages of blood-letting, which was to become a sort of sheet-anchor through the ages. For couching a cataract or opening an abscess, even a sharp thorn sufficed."

When the human intellect was sufficiently developed to permit working in metals, surgical instruments shared the improvement in knives, needles and weapons of war. Yet in the comparative modernity of the Ages of the Pharaohs we read that Zipporah, the wife of Moses, "took a sharp stone and cut off the foreskin of her son." The people who built the pyramids still employed the surgical methods of the dawn of time. This is indeed symbolic of the manner in which surgery—today the highest branch of medical art—was for untold centuries despised and neglected, the physician being an honored member of the community wherein the surgeon (when he had finally come to be recognized as such) remained a vagabond and outcast, even less respectable than the hangman and the barber. Though medicine attained a considerable degree of excellence in the golden age of Greece and Rome, surgery was not sufficiently recognized to have a distinctive name. Of its very existence we guess merely from indirect reference, as when Hippocrates says that "I do not cut for stone, but leave that to those whose business it is to do this." The Greeks considered the human body to be a temple, far too sacred to be defiled by exposure of those parts which a Higher Power had seen fit to hide from human eyes. Autopsies were not permitted for the same reason. When in later centuries the Christian doctrine of the resurrection of the body spread through the regions where once the gods of Mount Olympus had held sway, this acted as a deterrent to any examination of dead bodies which might have made it possible for surgeons to give aid to the living. Even in our own day this attitude of mind has not entirely faded, as was witnessed by the woman who was urged to permit the school doctor to remove her children's adenoids, on the ground that leaving them might so injure their health that they would fall an easy prey to any disease with which they might come in contact. She only shook her head and answered: "I aim to bury 'em with all their parts in."

During the Middle Ages the practice of medicine remained entirely in the hands of the clergy, and we find in the old ecclesiastical law codes many rules and regulations relating to this part of their duties. If a patient died after the administration of medicine, it was the will of God—why should man seek vengeance? But if he died after some over-zealous cleric had invaded an unbroken abscess with a knife, or otherwise interrupted the continuity of the covering an All-Wise Creator had seen fit to place about his "hidden parts," it was as plain as a pikestaff that the fatal outcome was due to this unwarranted interference with the course of nature. From this viewpoint it is not hard to divine why the practice of surgery was neither popular nor honored during the Age of Faith. The physician remained one with the priest and was reverenced as the mouthpiece of Deity. The sufferer who had the hardihood to seek relief by other means than charms, application of religious relics, or strange medicaments such as those brewed by the witches of "Macbeth," must seek it from the hangman or the barber.

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*Read at meeting, February 11, 1930.

Yet despite all this, the practice of surgery, as apart from medicine, was continued and gained in favor and employment as time went on. By the fourteenth century itinerant surgeons who cut for stone, couched for cataract, or dressed wounds, appear to have been fairly plentiful, for we learn that "in 1337, a strolling eye surgeon was thrown into the Oder because he failed to cure John of Bohemia of his blindness, and in 1464, Matthias, King of Hungary, issued a proclamation that whoever cured him of an arrow wound should be richly rewarded, but failing that, should be put to death. These barbarities," remarks Garrison, "point their own moral, for the strolling medieval mountebanks, in couching a cataract, sometimes put out an eye, mangled the viscera in 'cutting' for stone, and, in attempting to effect a 'radical cure' for hernia, as Baas says, not infrequently excised 'the radix of humanity itself.' Allbutt gives a striking picture of a medieval incisor who, while ligating an artery, paralyzed his patient's arm by crushing the musculo-spiral nerve, and was afterward pursued with curses by his miserable victim whenever he dared show himself in the street. If the Church 'abhorred the shedding of blood,' therefore, it is fair to suppose that in the first instance its aversion had the same human significance as the well-founded horror of hospitals and surgical operations which existed in the minds of the laity up to the end of the nineteenth century."

At a time when the monk's tonsure distinguished him from the layman with his abundance of hirsute adornment, the barber was a servant peculiar to the religious houses. As bleeding came to be regarded as the sovereign remedy for most human ills, and a good general preventative to be applied at regular intervals whether one needed it or not, the monks found it necessary to be bled at certain seasons and being themselves forbidden to serve one another in this capacity, it came about that shaving, hair-cutting and bleeding were naturally all delegated to the same attendant. Thus arose the 'barber-surgeons' to whom we owe the beginnings of the fine art of surgery as we know it today. Surely surgery may be called the Cinderella of the arts, for it was from the dust and ashes of the meanest servant's quarters that the surgeon rose to be the honored companion of kings. Where can we find greater romance than this?

With the Renaissance, the science of medicine shared in the re-birth of learning, and even its despised hand-maiden, surgery, felt the awakening impulse. As Osler has put it, "The sixteenth and seventeenth centuries did three things in medicine—shattered authority, laid the foundation of an accurate knowledge of the structure of the human body, and demonstrated how its functions should be studied intelligently." The ancient theories of Hippocrates and Galen, reverenced for more than a thousand years, were recognized for the futile nonsense which they appear to us today—the study of anatomy, no longer frowned upon, became the pre-occupation of the most learned men of the age, and anatomical illustration the lifework of the greatest artists. Osler cites Mundinus' work on anatomy, in which a "quaint illustration shows us the medieval method of teaching anatomy: the lecturer sitting on a chair reading from Galen, while a barber surgeon, or an 'Ostensor,' opens the cavities of the body." The Doctor of Medicine would not deign to touch the corpse—usually that of an executed criminal—used in demonstration, but in order to give his students the necessary insight into the workings of physiology was forced to call to his aid the despised "incisor." Thus did the surgeon make his first appearance in the ampitheatre where he is now the chief figure.

Late in the Middle Ages we find men living, working and writing who no longer feared to be known as surgeons. This was the age when medical schools first came into prominence and esteem, and at that of Montpellier—first chartered by a papal bull issued in 1289—lived and taught the first real surgeons of whom we have accurate knowledge— Henri de Mondeville and Guy de Chauliac. Though de Mondeville's treatise on surgery was never printed until 1892, it had an immense vogue in countless manuscripts long before Gutenburg's invention. Garrison tells us that "it abounds in directions of the rarest common sense for the aseptic treatment of wounds and in shrewd practical advice to the surgeon as to the conduct of his professional life. In opposition to the salve surgery of the Galenists, Mondeville advises simply to wash the wound clean and put nothing whatever into it, since 'wounds dry much better before suppuration than after it.' For hemorrhage he recommends styptics, digital compression, acupressure and torsion of the isolated vessel by means of a sliding-noose ligature: Some of his advice to his surgeon readers has an oddly modern tone. 'Many more surgeons know how to cause suppuration than to heal a wound.' 'Keep up your patient's spirits by music of viols and ten-stringed psaltry, or by forged letters describing the death of his enemies, or telling him that he has been elected to a bishopric, if a churchman.' 'Never dine with a patient who is in your debt, but get your dinner at an inn, otherwise he will deduct his hospitality from your fee'." That fees were not always easy to collect is suggested by this bit of wisdom, and the fact that the first surgeon of his time had this advice to offer gives us an insight into the roughness and steepness of the path by which he had climbed to eminence.

A far greater surgeon and from the evidences which have come down to us, one much nearer the prototype of the ideal healer of human ills, was de Mondeville's successor, Guy de Chauliac, who was twenty years old at the time of de Mondeville's death in 1320. He was educated for the priesthood, but in some way managed to get good instruction in anatomy at the University of Bologna, as well as studying at Montpellier, and the University of Paris, then as now the center of medical learning for that part of Europe. As the popes were in exile at Avignon at that period, the young surgeon selected that city as a good location for one of his attainments, and here he settled as a physician and chaplain to the Pope himself. His "Chirurgia magna" (Great Treatise on Surgery), written in the middle of the fourteenth century, is an excellent exposition of the art as practiced at that period. Personally he regarded the study of anatomy as the chief part of the surgeon's education, and he seems to have been practically the first educated physician who undertook the work heretofore left to ignorant menials—the performance of the operations for cataract and hernia. But even he, apparently, feared to cut for stone. He recommends excision of cancerous growths with the knife, if they are discovered when still small, but whether or not he actually did this himself is uncertain. He burned away small growths upon the skin, and employed the cautery also upon necrotic and gangrenous tissues. He advises placing a collar or protector of lead about ulcers and abscesses, very much as is nowadays frequently recommended for the treatment of corns and bunions. A broken arm or leg was to be suspended in a sling bandage, and for legs likely to shorten the weight and pulley is recommended—quite in the modern manner. In his discussion of the treatment of bones he does not neglect the teeth, and his volume gives us practically all we know of the practice of dentistry at that period.

But surgeons such as these two just mentioned were but points of light in the deep gloom which hung over the practice of their profession for many hundreds of years thereafter. Surgery continued generally to be in great disrepute, the frown of the Church and other causes already cited being more or less operative until comparatively modern times. Though the sixteenth century produced such men as Ambroise Pare in France; Tagliacozzi in Italy, known throughout the civilized world for his skill in replacing lost noses, and regarded today as the 1st of plastic surgeons; Pierre Franco, the Hugueenot refugee in Switzerland, who made the "cutting for stone" of the barber surgeons into the respected operation of lithotomy which has come down to our own day; and William Clowes, who was surgeon at Saint Bartholomew's Hospital, London, in the days of Queen Elizabeth; in general, as Clowes himself said, the surgeons of that time were "no better than renegades or vagabonds . . shameless in countenance, lewd in disposition, brutish in judgment and understanding." The actual status of these so-called surgeons, he informs us, was that of "tinkers, tooth-drawers, peddlers, ostlers, horse-gelders and horse-leeches, idiots, bawds, witches, conjurers, sooth-sayers and sow-gelders," with several other epithets not acceptable to modern ears.

Yet even among these, there were some who contributed not a little to the romance of surgery. In the year 1500, a German sow-gelder, one Jacob Nufer, found himself about to become a father for the fourth time. For nearly a week his wife lay in labor—all the midwives for miles around had struggled in vain to relieve her—the universal opinion was that she must die undelivered. Now though sows had a definite market value, whereas women were to be had for the asking, Jacob Nufer had found his wife useful and satisfactory, and he doubted if she could be easily replaced. He reasoned that what he was accustomed to do harmlessly upon his porcine patients might equally well be carried out upon a woman. He, therefore, prayed loudly to God to give skill and speed to his hand, and heedless of the horrified protests of the multitude of impotent bystanders, made use of his gelding knife to perform the first Caesarean section upon a living woman, which has a successful outcome. His wife lived to be seventy-seven and bore a large family in the natural manner. This had led students of the history of obstetrics to doubt whether Nufer actually incised the uterus, thinking that the evidence points rather to an ectopic pregnancy. But granting this, Nufer's feat still places him at the head of obstetric surgeons in priority, and it is an interesting reflection that he obtained his training and skill by practicing upon animals—exactly as do the surgeons in our present schools of medicine.

The advance of surgery during and after the sixteenth century may be well measured by the progress made in obstetrics and gynecology. While the conduct of normal labor was regarded as a purely feminine function for more than three hundred years after Nufer's exploit, the midwives more and more often sought aid when difficulties arose, and by the year 1700 we begin to hear complaints of the meddling of mere men, who, not content to advise and direct, had begun to take matters into their own hands, remaining in the lying-in chamber throughout the delivery—which was most indecent—and, worst of all, collecting fees for this outrageous interference, fees far in excess of those any woman could hope to command.

The obstetrical treatises make very fascinating reading—I speak here, not as a practitioner of this special branch of medical art, but merelyly from the literary point of view. As far back as 1550, when Pare wrote his treatises on surgery, the handling of difficult obstetrical cases had been carefully considered from the surgeon's point of view. He it was who revived the operation of podalic version, known to the ancients but abandoned and forgotten during the Dark Ages which succeeded the fall of Rome. Before Pare wrote, several treatises on childbirth had been published, but its surgical aspects had received scant attention. In an edition of the great French surgeon's works republished at Paris in 1840, the modern editor remarks that this description of podalic version is "the most original thing in the book," inasmuch as "neither in Roeslin nor in Rueff, nor in any other author before Pare, has version by the feet" been recommended, an operation which "certainly appears to have been of French origin, and indeed to have had its birth among the barber-surgeons of Paris," among whom Pare was originally numbered.

Pare had a pupil named Martin Boursier, who took for his wife a smart young woman who was called Louise Bourgeois. The fact that these two lived for many years under Pare's roof offers at least a partial explanation of the manner in which Louise came to be the foremost midwife of her time, attending Maria di Medici at the birth of the infant who later became Louis XIII of France. In her later years Louise wrote a manual for her professional sisters, which remained a standard work for a long period of time, not even being displaced by that of the 'man midwife,' Francois Mauriceau, which was published almost sixty years later. Mauriceau appears to have been one of the first—if not the very first—surgeon who devoted himself exclusively to 'female complaints.' That he entertained ideas somewhat in advance of his time is shown by his description of the manners and deportment proper to the 'man midwife' which I find quoted in Potter's Version.

The accoucheur "must be healthful, strong and robust; because this is the most laborious of all the operations of surgery; for it will make one sometimes sweat, so he shall not have a dry thread, though it were the coldest day in winter. He ought to be well shaped, at least to outward appearance, but, above all, to have small hands for the easier introduction of them into the womb when necessary; yet strong with the fingers long, especially the forefinger, the better to reach and touch the inner orifice. He must have no rings on his fingers and his nails well pared, when he goeth about the work, for fear of hurting the womb. He ought to have a pleasant countenance and be as neat in his clothes as in his person, that the poor women who have need of him be not affrighted at him. Some are of the opinion that a practitioner of this art ought, on the contrary, to be slovenly, at least very careless, wearing a great beard, to prevent the occasion of the husband's jealousy that sends for him. Truly some believe this policy augments their practice, but 'tis fit they should be disabused; for such a posture and dress resembles more a butcher than a surgeon, whom the woman apprehends already too much that he needs not such a disguise. Above all he must be sober, no tippler, that he may at all times have his wits about him."

One can easily picture Dr. Mauriceau—neat, dapper and cheerful—a far, far cry from the vagabonds and mountebanks of an earlier century. That the surgeon—at least he who devoted himself to obstetrics—had begun to take his profession very seriously, is indicated by the following passage from the work on obstetrics written by Pierre Dionis, another French accoucheur of the same period: "In difficult labors Nature often does a great deal, but in unnatural ones there is nothing to be expected from her; it is the surgeon alone that must do the business. The life of both mother and child is then in his hands and he has a fair opportunity given him to show his skill and dexterity in turning the child in the womb, and bringing it into the world, whereas, without this assistance, it can never see the light." In pursuance of this laudable endeavor, "the surgeon, having put a napkin or towel about his waist, must sit down before the woman on a low stool, as near her as may be, that he may give her the necessary assistance with the greater convenience and ease, and take a nap now and then in the intervals of her pains." He condemns the practice of some obstetricians who advocate binding the patient. "Has she not enough to complain of, though she be not bound with cords like a wretched criminal? . . . Three strong women, holding her safe, as we have directed, will do the business very well," to which Potter makes the addendum, "We can easily believe him!" That Dionis looked upon his profession with profound respect is evidenced by his reference to the measures necessary to combat placenta previa and eclampsia, then as now most draded among obstetric complications. "A great many women who have had most of these terrible symptoms," he says with pardonable complacency, "have been happily preserved by the friendly and seasonable help of the Artist" (emphasized by a capital A).

The seventeenth century saw the last of the strife between physicians, surgeons and barbers, which had been rampant for several hundred years. "In France," Garrison tells us, "the medical profession had consisted for centuries of an aristocracy of physicians, a petite bourgeoisie of clerical barber-surgeons, and proletariate of laic barbers or outcast surgeons, (barbitonsores), all hating and despising one another and adhering to rigid caste distinctions. When, after the foundation of the College of St. Come, the surgeon was in a manner assimilated to the status of the physician, he began to put on airs like the latter, wearing the square cap and long robe, substituting the device of three boxes of ointment upon his guild-banner for the traditional three basins (the barber's sign). . . . The physician had become a sterile pedant . . . and instead of studying and caring for his patients, tried to overawe them by long tirades of technical drivel, which only concealed his ignorance of what he supposed to be their diseases. . . . The lay barber, although an outcast and an outlaw, was in some respects the most worthy of all three, since he was driven to study nature at first hand . . . out of his clan had come Franco and Pare. . . . The curious isolation and sterile inefficiency of the French internists of the seventeenth century are strikingly revealed in the letters of Guy Patin, Dean of the Paris Faculty, who regarded the surgeons as mere "booted lackeys . . . a race of evil, extravagant coxcombs who wear mustaches and flourish razors, in 1686, however, an event occurred "which changed the attitude of the civilized world toward the despised and lowly surgeon. Every medical device had been vainly invoked to cure the exquisitely painful anal fistula from which the French king, Louis XIV, the greatest potentate of his age, had long suffered. When Felix, the royal surgeon, finally succeeded in healing it by operation. Louis' gratitude not only heaped wealth and honors upon Felix himself, but it redounded to the credit of the entire surgical fraternity. The royal surgeon was ennobled, and Felix's successor in this now enviable position was able to elevate permanently the social status of the surgeon, to equal or even excel that occupied by the physician. Thus did the "Grand Monarch," Louis the Fourteenth, "influence French medicine in three curious ways: His attack of typhoid fever gave an immense vogue to the use of antimony; his anal fistula brought about the rehabilitation of French surgery; and the fact that his mistress was attended by Clement, the royal accoucheur, in 1663, did much to further the cause of male midwifery."

From the beginning of the eighteenth century onward to our times, the surgeon came into his own. One must pick and choose now among a multitude of romantic eisodes which marked the careers of the men whose names shine most brightly upon the pages of surgical history. There is the career of Percival Pott, whose name is still with us in Pott's disease—tuberculosis of the spine—and Pott's fracture—unpleasantly familiar to most of those who have suffered the misfortune of a "broken leg." Pott's father died in 1721, when the future surgeon was scarcely seven years old. His mother married again, and the step-father managed in some way to dissipate the small property which had been left the boy, so that at seventeen he was without means to obtain an education. Nevertheless he managed to serve an apprenticeship in surgery and at twenty-one set up as a practicing surgeon, bringing his mother and little half-sister to London and installing them in a house of his own, thus fulfilling his avowed ambition of restoring his mother to her original social position. Laboring unceasingly he rose eventually to be chief surgeon of St. Bartholomew's Hospital, becoming the best known of English practitioners while he was still a young man. He found a husband for his sister, but remained unmarried himself until he was almost forty—until his mother died. He feared that to bring a daughter-in-law into the house he had so proudly provided for her might humiliate her and destroy the comfort and happiness it had been his privilege to bestow on her. Pott's fame rests largely on his surgical writings, and his treatment of the fracture of the fibula which still bears his name, and both of these were due to what, at the time, appeared a frightful misfortune. Riding from the hospital to make a professional call, his horse fell and rolled upon him, producing a bad fracture at the ankle. At that time the surgeon knew but one way to treat such an injury—that was, to amputate the leg at the knee. But Percival Pott, lying sorely injured in the filthy London street, was still the thoughtful and alert head surgeon of the greatest hospital in all England. Refusing to permit the bystanders to move him, he ordered them to buy a door and secure the services of two strong porters. This done, he gave exact dirctions as to how he was to be lifted upon the door, laid beside him upon the cobblestones, and just how the porters were to walk, so as to carry him with the least possible disturbance of the fractured ends of bone. Arrived at his own home, his frightened colleagues from the hospital gathered about him, condoling with him on the loss of his leg. Admitting that the proper attitude of a patient is to submit implicity to the judgment of his medical attendant, he yet made bold to suggest that the bones, having been so slightly disturbed, might yet be set so as to become reunited and he hoped earnestly that they would at least consider his plan bfore using the knife. Though convinced that he was but planning his own destruction, his colleagues did as he wished; the bone knitted, and Pott walked again, though it was many months before the final triumph of his treatment was assured.

During his long period of inactivity, the crippled surgeon turned to writing, and in rapid succession turned out treatises on hernia, head injuries, hydrocele, fractures and dislocations, and finally, the pamphlet on spinal caries, which first called the attention of the medical world to that particular form of a prevalent malady which is now known as "surgical" tuburculosis. Most of his bone tuberculosis patients were children, and we are told that he was particularly kind and patient with them, and gave unstintedly of his time and professional attention to the poorest, a veritable "labor of love." It is pleasant to think that after this devoted son felt himself free to marry, he found a congenial helpmate and, though middle-aged, became the father of a good-sized family.

Of far different temperament was the great English surgeon who came after him—John Hunter, who is usually ranked with Pare before him, and Lister, who came after him, as one of the greatest surgeons of all time. It is to Hunter that the surgical profession in America must look as its founder, for the first surgeons on this continent were, many of them, his pupils, and his influence was felt more strongly on this side of the Atlantic than that of any other European medical man. Hunter was so violent in temper and dogmatic in statement that he made few friends; yet so great was his learning, and so powerful his personality, that his impression upon the profession he chose abides until now. His pupils, and the pupils of those pupils, fill up the ranks of surgery in the early years of the struggling little nation, which now supplies medical men and knowledge to the entire civilized world.

Of these romantic figures I can mention but a few—the life of any one of them would supply material for an entire evening's consideration. My own attention has not unnaturally been especially directed toward Ephriam MacDowell, who was not a pupil of Hunter, but of the great John Bell of Edinburg. MacDowell, working in the then wild country of Kentucky, performed the first ovarian tumor excision ever undertaken, his patient riding on horseback sixty miles into Danville to undergo the operation, and returning by the same mode of conveyance only twenty-five days thereafter. In recalling the intrepidity of this pioneer gynecologist, we should not forget to honor the patient as well, for when we consider that anesthesia was not introduced until nearly forty years after, and that Mrs. Jane Todd Crawford was approaching her fiftieth year when MacDowell suggested the operation to her, her heroism fully equals, if it does not surpass, that of her surgeon.

Born five years before the declaration of Independence, MacDowell died in 1830, so that his entire life was passed prior to the revolutionary discoveries of anesthesia and asepsis. Fortunate, therefore, was James Marion Sims, who came into the land of promise and opportunity in 1813, and lived until 1883, when surgery, as we now know it, was an established fact. He began his professional career in Alabama, where he soon gained a reputation for skill and success as a surgeon. It was in the year 1845 that he was summoned far into the country to see a young woman who had fallen from her horse and sustained a serious uterine displacement. "In making a digital examination to correct the displacement, he hit upon the peculiar lateral posture" since known as the Sims position, and was likewise offered the suggestion which led to his designing the special duck-bill speculum still bearing his name, enabling the operator to see the condition 'as no man had ever seen it before.' He also made use of a silver wire to avoid sepsis, and a new catheter for emptying the bladder while a vagino-vesical fistula was in process of healing. These additions to his armamentarium, devised to meet an emergncy of country practice, now put him in a position to treat successfully the fistula just mentioned—up to that time the most intractable condition with which gynecologists had to deal.

Thus did the romance of American surgery have its beginnings. The rest of the story is just as wonderful—but as we approach our own time, the focus of our glass changes—the achievements of Crile, Carrell, and the Mayos—to mention at random a few of many eminent names—are not yet romance. That view of them remains to be taken by the generations which come after us.

Benefit of Radiology in Diagnosis

BY W. R. BETHA, M.D.

Sir William Crookes, an English Scientist, invented the Crookes Tube in 1878. Wilhelm Konrad Roentgen, born near Zurich, Switzerland, a professor in University of Wurzburg, experimenting with the Crookes Tube in April 1895 discovered X-rays, and reported his discovery in September of the same year.

The laboratories of those days were crude and the apparatus was very inferior to the present day modern apparatus. The development has been too rapid and is too well known to need discussion.

Today we have in this comparatively new apparatus one of the leading and most widely used methods of diagnosis of human ills. Practically every system of the human body can be visualized thru the use of X-Rays. Thus one brings into vision the shadows most acute of all the special senses of man, the human eye.

Such study has become so important that at the International Congress of Radiology in Stockholm in 1928 a committee of leading radiologists from every country in the world was formed to formulate teaching [illegible] instruction in Radiology in the Medical Colleges all over the world.

In the X-Ray study of the skeleton one looks for malformations such as ill shaped bones, crooked and irregular, supernumerary, or even the absence of some bones; pathology of bone as osteomyelitis, osteitis, malignancies, cysts, osteoma, periosteal changes, rickets, scurvy, osteo-malacias, etc.

Fractures of various kinds were the first use of the rays in diagnosis. Dislocations of the joints, epiphyseal changes, arthritis, sesamoids, and loose particles of bony formation about the joints are all detected by the X-Rays.

The nasal accessory sinuses are very accurately studied by radiographs. The size, shape, degree of development, and absence of the sinuses are noted. Teeth may sometimes be found totally or partially in the maxillary sinuses. Cloudiness or density denoting disease, sclerosis of bony walls in chronic cases may be determined. Also growths, as maligant, osteoma and polyps. In the study of sinuses opaque substance as lipiodol can be used to an advantage in detecting growths and the amount of thickening in the mucosa.

The fluoroscope is of value in addition to the radiograph in most studies, especially in the chest where we have the cardio-vascular, the pulmonary and part of the lymphatic systems.

The X-Ray study of the cardio-vascular system is very important. The size, shape, position, pulsation, and border wave of the heart are most important in diagnosis. General enlargement is found in myocarditis, hypertrophy, dilatation and pericarditis with effusion. Valvular diseases cause enlargement of one or both of the auricles or ventricles. Study of the aorta is made in reference to dilations, aneurysms, calcifications and length of the aortic chord. The cardio-vascular system should be radiographed at the distance of 7 feet from the target of the tube to the plate with the patient's anterior chest border in contact with the plate.

Pathological conditions of the pulmonary system, which is composed of parenchymatous structure, bronchi, lyphatics, blood supply and pleural covering, are successfully studied by roentgenology. Its use is shown in conditions most commonly affecting the parenchyma such as tuberculosis, characterized by flaky dense lesions of varied formations; pneumonia usually affecting an entire lobe of lung or may be lobar in type; abscesses that are usually centrally located and circumscribed; fungus infections which are rare and are characterized by flaky or somewhat starlike areas thruout one or both lungs; malignant lesions characterized by small rounded nodules either single or multiple; cysts characterized by sharp well defined masses varying considerably in size.

Atelectasis is not uncommon especially in new borns. It is characterized on the X-ray plate by general haziness of a part of one or all of both lungs. Pneumothorax may occur in one or both sides with partial or complete collapse of the lung by air in the pleural cavity.

In the trachea opaque or non opaque obstructing foreign bodies may be demonstrated. There may be collapse of rings of the cartilage from pressure without. Tracheal or bronchial fistula may occur from esophageal lesions. These are easily demonstrated by barium taken by the mouth passing into the bronchi.

The bronchi are ofter increased in density by the acute respiratory lesions as influenza, whooping cough, acute colds etc. Producing bronchitis. Bronchiectasis and abscess cavities are demonstrated by lipiodol. Pleuritic changes are characterized by increased density ranging from a slight haziness to complete cloudiness. Fluid or pus, either general or localized in the pleural cavity, may be detected by the lines of thickened pleura or by the fluid levels producing a more dense line.

Enlarged lymph glands may be seen from acute infections, mediastinitis, mediastinal abscesses secondary to cardio-vascular diseases, tuberculosis, enemias, lympho-sarcoma, carcinoma, Hodgkins disease, etc.

Sub-sternal thyroid glands in adults and thymus glands in children are other causes of widened superior mediastinal shadows.

The diaphragn when studied on radiograph and fluoroscope gives valuable information. Fixation on the affected side is a definite change and easily recognized. Limitation of excursion is due either to lesions above or below the diaphragm. Diaphragmatic hernias of abdominal viscera from weakened openings or lacerations are noted.

The alimentary tract is better studied by radiology than perhaps any other one diagnostic method. The teeth are radiographed for deformities, abscesses, and pyorrhea pockets.

Opaque substance is used in the study of the entire gastro-intestinal tract. In the examination of the esophagus foreign bodies, anomalies, atresia, tracheal and bronchial fistula, cardio spasms, dilations, deformities from disease as malignancy, variation in normal course from pressure, strictures, etc. are noted. The stomach is studied for type, shape, size, position, motility, emptying time, deformity from ulceration and malignancy, external pressure, foreign bodies and size of pyloric opening. The duodenal cap for size, location, deformity as from ulcer, diverticulae, atresia, adhesions, etc. The small intestines for motility, constrictions, foreign bodies, deformities, and location. The appendix for motility, constrictions, foreign material, emptying time, etc. The colon for location, formation of haustra, deformities as ulcerations, malignancies, strictures, diverticulae, spastic areas, polypoid or other benign growths, foreign substances, emptying time, and rectal fistula. Hernia may occur in the intestinal tract thru the diaphragm or abdominal wall.

Obstructions of any part of the ailmentary tract can usually be accurately located by the gas accumulated in the tract above the obstruction or by opaque substance.

Other abdominal viscera which may be diagnosed by X-ray: The liver is studied for size, location, and density. Abscess pockets may be easily located by the increased density and gas in the density. Cysts can sometimes be located. The gall bladder can be very accurately studied by the Graham-Cole method of visualization. Stones may be shown in the gall bladder with or without the opaque substance. Stones, new growths, and enlargement of the pancreas may be demonstrated. The spleen can be outlined on a radiograph and studied for size, density, and calcifications.

Study of the urinary tract has made great strides in recent years. The use of plain radiographs will give the size, density, and location of the kidneys, the presence of stone shadows in the tract. By pyelograms, ureterograms, and cystograms one is able to locate pathology in all parts of the urinary tract as acute nephritis, pyelitis, hydronephrosis, pyonephrosis, tuberculous infections, neoplasms, congenital conditions, strictures, and angulations of ureters, etc. Stones along the ureters are accurately located by introduction of opaque catheters and radiographs with a double tube shift.

The genital organs may be studied for calcifications of ovaries, fibroids, cysts, etc. The use of pneumo peritoneum gives considerable aid in this as well as the study of all the abdominal viscera. Opaque substances as lipiodol will outline the uterine cavity and tubes thus determining the size of the uterine cavity and reveal the presence of any neoplasm encroaching on its lumen. The size, length, location, and patency of the tubes can be easily determined.

Pregnancy after the fourth month can be easily shown by radiograph, revealing the presence of fetal bones. The differential diagnosis between cysts, abdominal tumors, ascites and pregnancy may be made.

The brain and spinal cord are studied both by radiographs, plain, and with opaque and rarefied substances. On plain radiographs one locates blood vessel markings, digitations, and densities, and occasional calcified areas in skull wall, the size and shape of cella notch, and pineal gland if calcified. The size, shape, location, and deformities of the ventricles and their foramina may be noted by replacing the ceregro-spinal fluid with air and radiographing in several positions. Hydrocephalus causes dilatation. Tumors cause deformity and displacement.

The spinal cord and canal are studied by plain radiograph for erosions on the bodies of the vertebrae and encroachment on the lumen of the canal by the vertebrae. Air may be injected into the lower canal and observed under the fluoroscope. By changes in position of the patient the air may be seen passing up the entire length of the spinal canal, thus locating obstructions. Radiographs are also of use in determining the course and source of the circulation of the air in the canal. Lipiodol was formerly used for this purpose but was found to be too irritating. Gas in the tissues as from gas gangrene, emphysema, and in abscesses where gas is generated is easily demonstrated.

Location of foreign bodies in any part of the body, the eye, and soft tissue is very accurately made by radiographs.

To accomplish any task successfully it is necessary not only that you should give it the best that is in you, but that you should obtain for it the best that there is in those who are under your guidance.—George W. Goethals.

"Cast aside business forever except for others—Man must have an idol. The amassing of wealth is one of the worst species of idolatry. No idol more debasing than worship of money."—Andrew Carnegie.

Ole Miss Medical News

By Woodard D. Beacham

Having completed the courses of the first semester and successfully stood the mid-year examinations, students at the Ole Miss Medical School are again hard at work. This semester the first year class will complete the following courses: Anatomy, Neuro-Anatomy, Histology, Embryology, and Physiological Chemistry. The curriculum for the second semester of the second year in medicine includes: Pathology, Pharmacology, Obstetrics, Physical Diagnosis, Clinical Diagnosis, Medicine, Physiology, and Minor Surgery. The first semester the first year group studied: Osteology, Anatomy, Histology, and Physiological Chemistry. During that period, the second year men studied: Bacteriology, Physiology, Materia Medica, Medicine, Physical Diagnosis, Topographical Anatomy, and Minor Surgery.

Dean P. L. Mull will represent the University of Mississippi School of Medicine at the meeting of the Council on Medical Education and Hospitals of the A. M. A. to be held in Chicago beginning February 13th.

Dr. Rowland Begins 29th Year of Service to the Ole Miss Medical School

Dr. Peter Whitman Rowland enjoys the distinction of being the only member of the faculty of the University of Mississippi School of Medicine to serve that institution continuously since the establishment of the school in 1903. Since that time he has occupied the chair of Materia Medica and Pharmacology.

This highly respected professor, born of Virginia stock and with an ancestry traced to John Rowland of Surrey England, who came to America in 1635, was educated in the private schools of Memphis, Tenn., and at Oakland Academy. He received his medical degree from the Memphis Hospital Medical College in 1882 and settled in Coffeeville, Miss., where he engaged in the practice of medicine for fifteen years. After the lapse of that period, he removed to Oxford.

In 1887 he took post-graduate work in the hospitals of New York and Philadelphia, attending courses at the New York Polyclinic and doing special work in Physical Diagnosis at Northwestern Dispensary. Several years later he returned to Philadelphia to study certain phases of hospital work in thas city.

Dr. Rowland has long been prominently identified with the medical profession of Mississippi. He served as president of the State Medical Association 1894-95, having previous-corresponding secretary respectively. He was appointed to the State Board of Health in 1900 by Gov. Longino, and re-elected to that position in 1904 by the Medical Association. He has been a Fellow in the American College of Physicians for many years.

He was university physician from 1907 until 1925, at which time he resigned to devote his entire time to teaching and experimentation. During these eighteen years, in which occurred the epidemics of influenza of 1918 and 1925, he personally treated 550 cases without suffering a single mortality.

Dr. Rowland might well be proud of the fact that he organized the department of Pharmacology at the University of Mississippi Medical School. This department, separate and fully equipped, was one of the first to be organized in the entire country. And, although there is a tendency at many medical schools to place less and less emphasis upon Materia Medica and Pharmacology, these courses are still regarded as being of great importance at the Mississippi Medical School and are treated as such.

Dr. Rowland is the father of Dr. Whitman Rowland, of Memphis, and Herron Rowland, druggist in Oxford.

He is intensely interested in matters of science and has a deep appreciation for art. Chess is one of his favorite diversions and he enjoys an occasional round of golf.

The Birmingham Meeting of Southern Medical Association

Under a Republican or a Democratic president, in good times or bad, rich or poor, a large number of physicians of the South have turned out each November but one for the past twenty-six years to greet one another at the Southern Medical Association's annual meeting. Each year has shown a greater enthusiasm for the coming together and has produced a progressively more scientific array of section and clinic papers, scientific exhibits and discussions. These have indicated the steady increase in population, education, and achievement of this section of the country. This year, despite the uncertainty of the times, 1,241 physicians, 218 women guests and 110 other visitors registered, making a total of 1,569 persons present at the meeting.

The classical address of the President of the Association, Dr. Lewis J. Moorman, "We Owe a Cock to Aesculapius," and the general clinics arranged by him, were of interest to a large group of men. It is difficult to say which of the twenty sections and conjoint meetings was most enjoyed. In attendance they ranged from enthusiastic and intimate small groups to the larger assemblies of several hundred men in the sections, for example, on internal medicine and general surgery. Technical and scientific exhibits were ably prepared and were studied by practically all visitors to the meeting. The premeeting clinics presented by members of the medical profession of Jefferson County (Birmingham) were well received.

Thanks of the Association are due to the General Chairman of local arrangements in Birmingham, Dr. James R. Garber, to the President of the Jefferson County Medical Society, Dr. John D. Sherrill, and to the many local committees which worked with them throughout the year in preparation for a large and happy meeting. Thanks are due as well to the General Chairman of women's activities of the meeting, Mrs. Sid W. Collier, to the Co-chairman, Mrs. S. L. Ledbetter, to the President of the Woman's Auxiliary of the Jefferson county Medical Society, Mrs. John M. Akin, and the many committees of women working with them, for their hospitality to the women guests of the meeting. It is certain that an impression of welcome and of the true old-fashioned antebellum Southern hospitality of which one has read was given to this year's guests of the meeting, both men and women.

NEW OFFICERS

The following officers of the Association were elected for 1933: President, Dr. Irvin Abell, Louisville, Kentucky; First Vice-President, Dr. James R. Garber, Birmingham, Alabama; Second Vice-President, Dr. Hugh J. Morgan, Nashville, Tennessee; Chairman of the Council, Dr. Homer Dupuy, New Orleans, Louisiana; and Chairman of the Board of Trustees, Dr. J. Shelton Horsley, Richmond, Virginia.

The January issue will have a complete roster of all officers for the year.

AWARDS

The medal for scientific research of greatest value by a physician in the South was presented to Dr. Evarts A. Graham, of St. Louis, Missouri, for his outstanding research work, especially on the diagnosis and pathology of inflammatory diseases of the gallbladder and liver. Only four times has this medal been awarded in the life of the Southern Medical Association. The Committee on Scientific Awards which recommended Dr. Graham as recipient of the medal this year consisted of three men who had previously received the same honor for distinguished investigation in medical subjects: Dr. C. C. Bass, New Orleans, Louisiana; Dr. J. Shelton Horsley, Richmond, Virginia; and Dr. Kenneth M. Lynch, Charleston, South Carolina.

Awards among the scientific exhibits were made as follows: first award to Dr. Roy R. Kracke, of Emory University School of Medicine, Atlanta, Georgia, for an exhibit on the experimental production of leucocytosis; second award to Drs. W. C. Langston and Paul L. Day, of the University of Arkansas School of Medicine, Little Rock, Arkansas, for their exhibit on cataract in vitamin G deficiency; and the third to Dr. Seale Harris, Birmingham, Alabama, for a report of clinical studies upon hyperinsulinism.

A loving cup, the personal gift of Dr. James R. Garber, the General Chairman of the Birmingham meeting, was presented to Mr. C. P. Loranz, Secretary-Manager of the Southern Medical Association, as a testimonial of the donor's appreciation of the character and capacity of this faithful officer during his twenty years of service.

The January issue will contain an account of the golf and trap shooting tournaments and the winners of the trophies.

The invitation of the Richmond Academy of Medicine to hold the next annual meeting in Richmond, Virginia, November, 1933, was accepted.—Southern Medical Journal, December Issue.

You will read with interest an account of the 26th annual meeting of the Southern Medical Association. It was a splendid meeting and well attended considering the "times." The meeting breathed the spirit of Harris, Dabney, and Lorenz and this is enough said. They know how to entertain, they know the science in its minutest details, and are adept in the application there of. Headquarters were at the Tutwiler Hotel. For good service and southern hospitality, it is not to be surpassed.

The entire program was unusually good. The arrangement and the execution of same was far above the average. The exhibits were good considering and courageously displayed. A splendid fraternal spirit prevaded the entire meeting. It was quiet and orderly and there was a ring of sincerity in almost every voice.

Due to financial conditions, stenographers for the sections were not used. Each man had his discussion written ahead and the discussions were much better. Men who wished to discuss a paper made his notes as he listened and spoke with much more precision than usual. This saved the association we were told about fifteen hundred dollars, the price of sixty bales of cotton. We advocated and insisted on this plan for our society several years ago. There is no harm in the medical profession economizing especially so when it brings efficiency.

There are many things to be said about the meeting, but the chiefest of attractions was the presence of Dr. Rudolph Matas of New Orleans. He was very reserved as usual, but when urged to his feet he manifested his same keen interest in every medical subject and his discussions indicated that he was informed to the last word in all of its branches. It was indeed a treat to hear his profound words of wisdom. He may not be the most expert in converting medical knowledge into greenback, but in versatility in every subject and in every branch of medicine, surely he is the world's chief. The God of Creation lavished the material for a thousand men when he endowed Dr. Rudolph Matas with his professional mind, his medical soul and his missionary heart. May his fountain of wisdom and knowledge flow many years yet for benefit and the edification of the medical world and for the relief of the human ill.

ADDITIONAL EDITORIALS

The exhibitors at the "Mid-South" are helping very materially to make it possible for us to have the type of meeting we are having. They help to finance the meeting. They talk it. They tell the profession what it is, what it means to them, as their representatives go about. You may learn much from the exhibitors. The book companies and the biological houses et al are working hand in hand with us. We are all one in a great cause. They bring you the latest instruments, the newest books, and the most recently approved machines and biologicals. Be wise. Visit their booths. Tell them that you appreciate their presence and their co-operation.

Everything else being equal it is no harm to trade with the companies who advertise in The Mississippi Doctor. "Scratch the man's back who scratches yours" in no mean policy. We deeply appreciate our advertisers.

Grab your suitcase and take out to the "Mid-South." It is a great treat. You get the last word on all the subjects by the greatest authorities we have. And it is always good to enjoy the hospitality of Memphis. She has the warmest heart and the most cordial hand.

You will read with interest the write up of Dr. P. W. Roland. He is a fine type of the true physician. He is one of the most scholarly men within the bounds of our state. He is a fine teacher. He is courtly and dignified. His scholarship is highly polished. We appreciate his services as an instructor at Ole Miss.

1933 Officers of the North Mississippi 6-County Medical Society

The officers elected for the current year are as follows:

Dr. G. A. Brown, president; Water Valley.

Dr. A. H. Little, secretary; Oxford.

J. J. McGowan, vice-pres., Benton county; Frank Ferrell Delegate to State Association.

C. M. Murry, vice-pres., Tippah county; R. M. Adams, Delegate to State Association.

I. B. Seale, vice-pres., Marshall county; D. R. Moore, Delegate to State Association.

H. N. Mayes, vice-pres., Union county; C. M. Speck, Delegate to State Association.

G. H. Wood, vice-pres., Panola county; G. H. Wood, Delegate to State Association.

W. H. Phillips, vice-pres., Lafayette county; J. C. Culley, Delegate to State Association.

R. J. Criss, vice-pres., Yalobusha county; G. A. Brown, Delegate to State Association.

Biopsy in Mammary Cancer

BY JAMES EWING, M.D.

The evtent and severity of the raperical operation for mammary cancer calls for a positive diagnosis in every case. Since women are now coming earlier for diagnosis of mammary disease, and often before the characteristic clinical symptoms of established cancer have developed, the diagnosis of these conditions has become more difficult and biopsies are more frequently required.

The practice of removing apparently benign nodules from the breast in a doctor's office and waiting two or three days for a report from a distant pathologist often leads to serious situations, and, in the opinion of some surgeons, may imperil the patient's changes for a cure even by a radical operation. The mechanical trauma from such a biopsy may well dislodge cancer cells and cut across and loosen cancerous lymphatics, while the delay of some days gives opportunity for the dislodged cells to reach the distant lymph nodes. The hyperemia of the inflammatory process may also stimulate tumor growth and facilitate the local growth and even the dislodgement of more active tumor cells. There have been some observations which indicate that these undesirable events actually occur and it is reasonable to assume that they do occur. Therefore the conservative surgeon will not remove a tumor nodule from the breast except in a surgical operating room where he is prepared to have an immediate diagnosis made proper operation preformed at the same time.

There is a difference of opinion regarding the best method of performing the operation for a biopsy of the breast. Some surgeons prefer to cut directly into the tumor, make the diagnosis on the gross appearance which is usually specific, or cut out a piece of the tumor for frozen section. If the tumor proves to be cancer, the wound is closed over a sponge soaked in 10% formalin. They then discard the instruments and gloves used in the exploration, prepare the skin anew, and proceed with the operation indicated. This is a very direct and expeditious method. It avoids much trauma inevitable in a local excision which requires cutting on all sides of the tumor nodule. In the case of bulky tumors it may be the best method.

In the case of small tumor I think it is safer to remove the whole tumor, together with a wide area of normal breast tissue, using extreme care not to squeeze or roughly handle the cancerous mass. This procedure avoids cutting into cancerous tissue, and if is done with extreme care not to squeeze the tumor cells should not be disloged.

An experienced surgeon or patholgist should be able to recognize the great majority of malignant tumors of the breast by gross examination of the cut surface of the tumor. Unless he can do this it is obvious that the tissue

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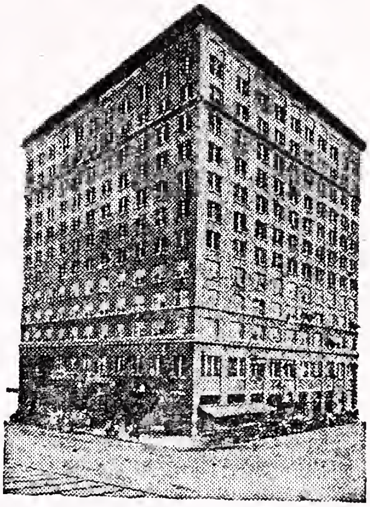

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H. O. PATE,
Manager

chosen for microsopic section may not contain the malignant tumor. Therefore great importance attaches to the gross diagnosis, which should be relied upon wherever possible. The extent of the disease also can be told only by gross examination. The cicatricial character, resistance, opacity or translucency, and the chalky streaks of carcinoma are generally specific. Frozen section is therefore often unnecessary but should be made in all cases which are in any respect doubtful to the particular surgeon or pathologist concerned. This diagnosis should be made at the operation and the appropriate procedure carried out immediately.

There are some lesions in the breast in which it is difficult for any surgeon or pathologist to state positively whether the condition is malignant or benign. Hence the surgeon must not assume that by obtaining a microsopic diagnosis he has secured positive information. In such cases the clinical data, age of patient, extent and duration of the disease, condition of lymph nodes, and especially the gross characters of the lesion should be given much importance in the decision. Under these circumstances some surgeons would err on the side of caution and perform the radical operation. I believe it is unfair to the patient to perform a radical mastectomy unless the diagnosis of carcinoma is positive. There are many precancerous and suspicious lesions in the breast which are clinically benign, while a true carcinoma is nearly always obvious to a pathologist of adequate experience. When a substantial doubt exists about the nature of a microscopic section of a breast tumor, it is generally not cancer.

Program of North Mississippi Medical Society

Held at Water Valley, Miss., Dec. 14, 1932

Invocation.

1. "Immediate and Ultimate Prognosis of Certain Types of Cardio-Vascular Disease" by Dr. Whitman Rowland, Memphis. Discussion opened by Drs. S. L. Cox and J. S. Donaldson.
2. "Umbilical Hemorrhage" by Dr. R. G. Grant, Holly Springs. Discussion opened by Drs. C. M. Murry and and R. J. Criss.
3. "Duodenal Ulcer" (with motion pictures) by Dr. C. M. Speck, New Albany. Discussion opened by Drs. E. S. Bramlett and H. N. Mayes.
4. Case Reports, (Society members are urged to present briefly any cases that might be of interest to the society).

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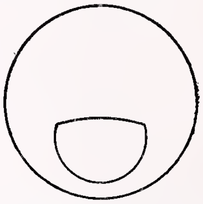

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VOL. 10. BOONEVILLE, MISSISSIPPI, MARCH, 1933 NO. 10

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Unselfishly, he yields his scheme or plan
To men of his profession—for sake of man!
Nor does the moral being of himself neglect
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Unhampered by wild fancies, or by fame;
Finally, all human ills to tame.
This is the happy Doctor—This is He
That other medical men should wish to be.

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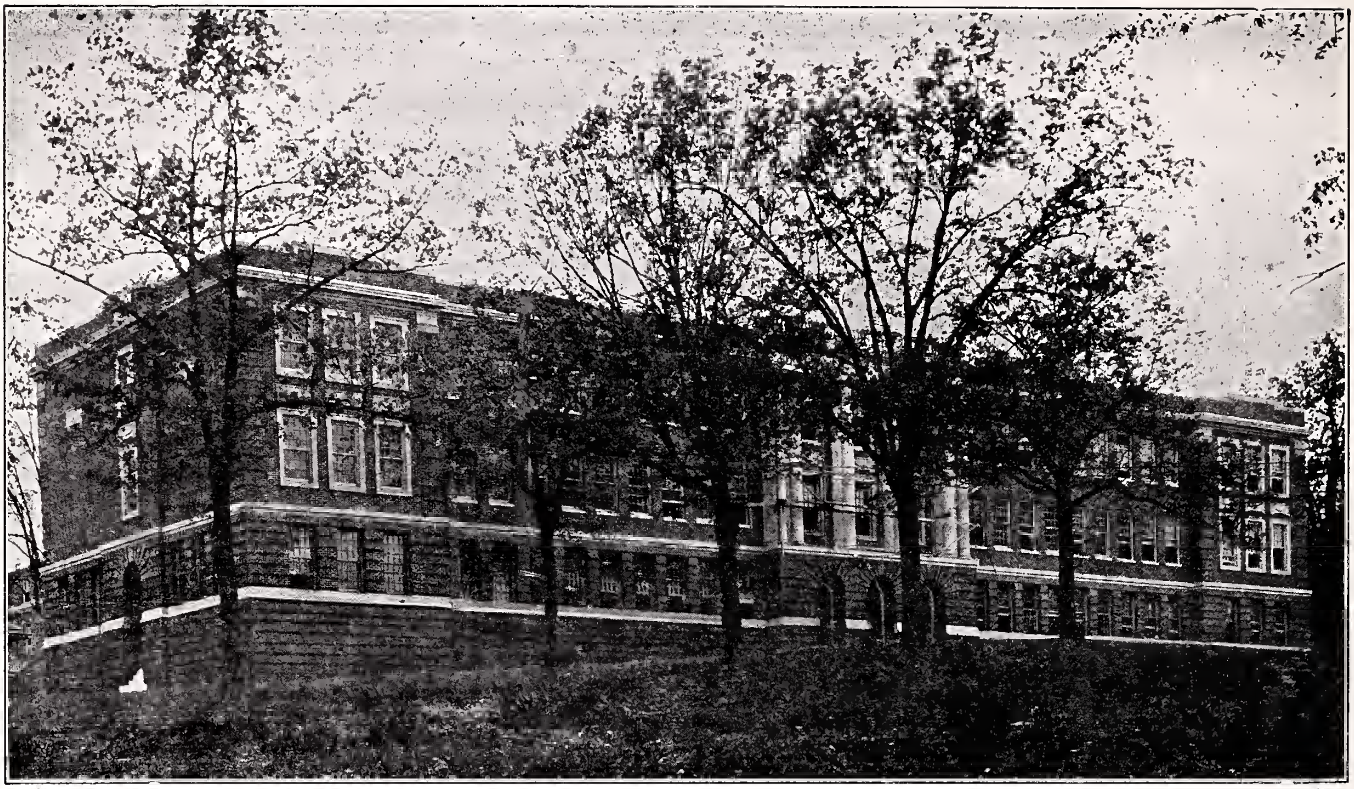

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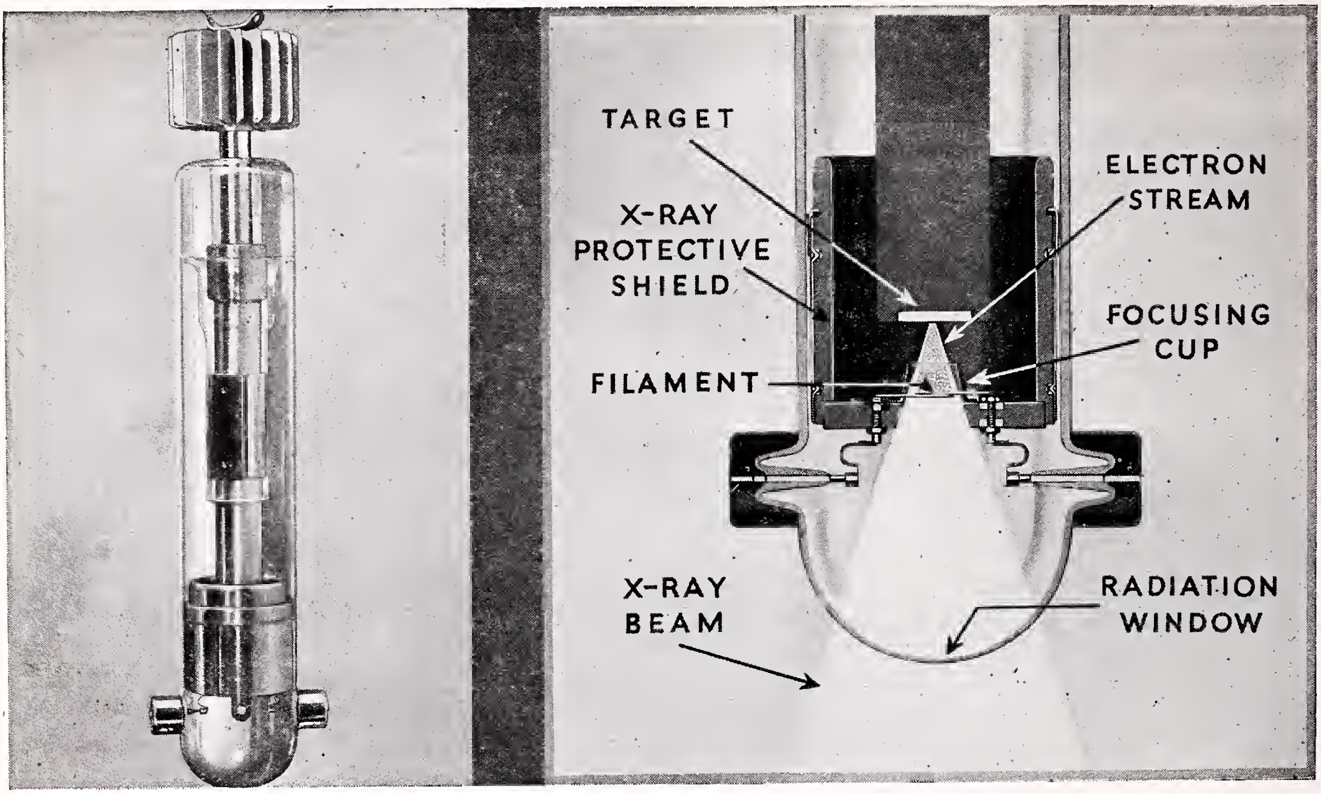
Dr. A. B. Dancy of Jackson, Tennessee, the now fullfledged, active and able president of the Mid-South Post Grduate Medical Assembly. He will carry the banner forward, he will carry it high and gracefully. Friend neighbor, Dancy, we are with you and for you.

Here is a likeness of our own efficient secretary, Dr. J. M. Acker, Jr., of Aberdeen. Dr. Acker is also president of the Mississippi State Medical Association. He is actively doing honor to this most honored position. For Southern culture and refinement Aberdeen, we are sure, is not surpassed in our state. Dr. Acker is of and has become a liberal part of same. He is immaculate in appearance, magnetic in personality, and like Franklin D., a man of few words, but wise decisions. He speaks to the point and covers the subject. He is a modern cut of the "general man" who can do well or better nine tenths of the large practice that comes to him. The state association is going forward under his leadership as has the North East Mississippi 13-County Medical Society.



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MID-SOUTH POST GRADUATE MEDICAL ASSEMBLY

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Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1870.

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It is not enough to "know your pills," you need to know the individual to whom you give them in all his relations to life.

So it would appear that Tuberculosis is three times more fatal to the negro as to the white and nine times to the Indian.

We hope you like our issue this month. You will be delighted with the papers of Drs. Brown, Harris and McDaniels, we are sure.

The forgotten man in the profession is the general practitioner, but although rejected he will again become the corner stone in the modern structure of preventive medicine.

A philosopher said, "never put off until tomorrow what you can do to day," but medical science is saying to you, "never have any disease today that you can put off until tomorrow.

The Mississippi Doctor is the official organ of the Mid-South Post Graduate Medical Assembly. You will want the splendid papers that it is to carry this year. It may be had for one dollar, for one year.

You will read the very beautiful tribute to Dr. Kirk in the Amory News. It was written by Dr. Bryan. Every word was deservingly and well said. We keenly regret the loss of this one of our number. The Mississippi Doctor offers its sincerest sympathy to the bereaved ones.

Dr. G. S. Bryan reports that he attended the last rites of Dr. J. W. Young of Grenada on Feb. 14th. We did not know Dr. Young personally, but from what we have been told he was one of our finest types of the old school, one of the patriarchs in general practice, the family physician. His type has not lived in vain. We need the quality of heart, mind, and soul in the profession always.

Dr. Peter W. Rowland, of Oxford, a charter member of the Tri-States Medical was unanimously elected president-elect of the Mid-South Post Graduate Medical Assembly at its last meeting. In so doing it most honorably bestowed its highest honor upon one of its most honored members. Dr. Rowland has been an instructor at Ole Miss for many years. He is scholarly, he keeps up with the best. He is dignified and polished, he is a corner stone in medical ethics. We feel proud of our president-elect.

Secretary Acker informs us that we have a fine program in the making for our meeting on March 21st at Macon. Dr. E. Lawrence Scott of Birmingham is to be the visiting orator. His subject is Infantile Paralysis. Lilly, McRae, and Rayburn are also on the program. The meeting will begin at two o'clock. No banquet is to be had. And by the way, may we suggest that for this year we do not plan a banquet at any place. We have some towns that we would like to visit, but which would be burdened somewhat to furnish entertainment. We are just thinking that it might be well to yield this much more to the depression for this year. Let us all meet at Macon March 21st at 2 o'clock.

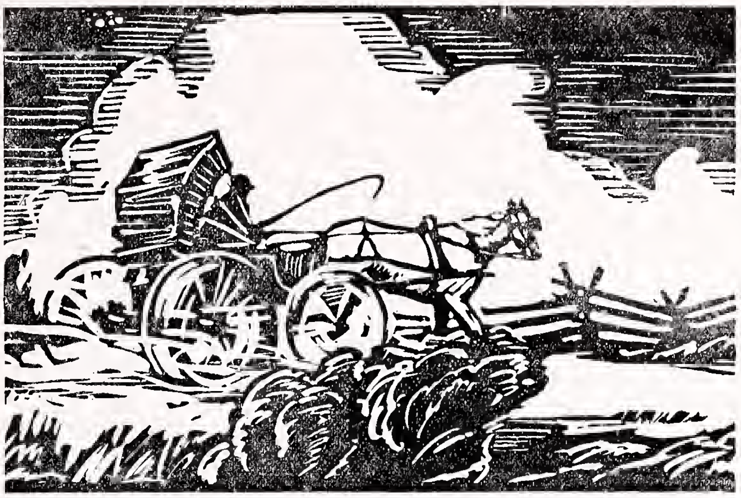
If you have not paid your local dues, do your dead level best to do so. Some way, some how you must pay your dues. It is a little debt that you owe to organized medicine. It should be as urgent as your grocery bill. You need the mental food that it brings to you. You need it as badly as you do meat and bread. You clientele needs you to have it. If you can understand what your local society means to you, then paying the dues will be easy. "The work we love to do physics pain," the bills we want to pay worst are the ones we pay the easiest. Our society is sick for the want of dues. Pay your dues as you would give aid to a sick mother. If you are to have a long and a successful professional life you must honor yourself and your society with the regular payment of your dues.

The two year medical course at Ole Miss should be continued. It can stand the test with its former graduates. It has the medical spirit. It teaches the student what he needs to know to practice successfully. Stone buildings and marble floors do not make a medical school. It's the men, it's the teachers, it's the spirit and just enough equipment to do the work. All important things can be done with comparatively simple equipment. The doctor of today needs to be taught how to do with less. The doctor should learn the economy side in the practice. We are also depending too much on the mill methods of diagnosis. Some schools are teaching the students into helplessness. The Ole Miss Medical School must live and go forward.

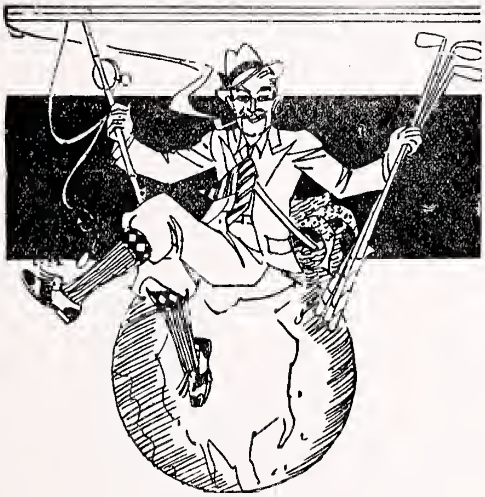
The Mississippi Doctor is now the official organ of the Mid-South Post Graduate Medical Assembly. During its entire life it has been a booster for this association. As the official organ now of the Northeast Mississippi 13-County, the North Mississippi and the Mid-South, and with the special papers that it will publish from time to time it hopes to give its readers the best of service. From its pages you will get the views from the ranks in the profession out on the firing lines and you will get the last word from the ablest authorities in the United States. The Misssissippi Doctor has been the active promoter of the community hospital. Its society territory has a greater number for the number of counties perhaps than any other section in this country. This journal discusses our medical problems from time to time. It is glad for you to join in the discussions from time to time. Our depression price for this year is one dollar only. Let us know if you want the journal. You can ill afford to miss the papers that are coming out.

The challenge to the profession is to deliver modern medicine to the masses at a cost at which it may be utilized. Opinions are varied as to how this is to be done. Some think state medicine will come and will do it. Others think medical insurance will be the answer. Regardless of who says what the community hospital is the best answer so far. The community hospital carries palliative, curative and preventive medicine to the civil firing lines of rural life. The small hospital, will develop a little medical center in each community. Through its aid the general surgeon and the general practitioner can make more money with less charge to the individual. The community hospital will lead the profession from the over-crowded cities and give us a equitable distribution. It will save the patient half the bill in travel to the city. It will raise the batting average of the general men of the profession. It will meet the demands of the machine age for service out at the cross roads. It will help the flow of population back to the country that is needed at the time. The community hospital will develop into a postgraduate teaching center. It will develop each community to take care of its own medical and health problems. It will be a big boon in teaching preventive medicine and preventive surgery. The small hospital and the well ordered clinic with a little funds for charity from the national, state and municipal governments and from church and philanthropy will bring modern medicine out to the commercial firing lines at less cost to the masses and with more profit to the general practitioner.

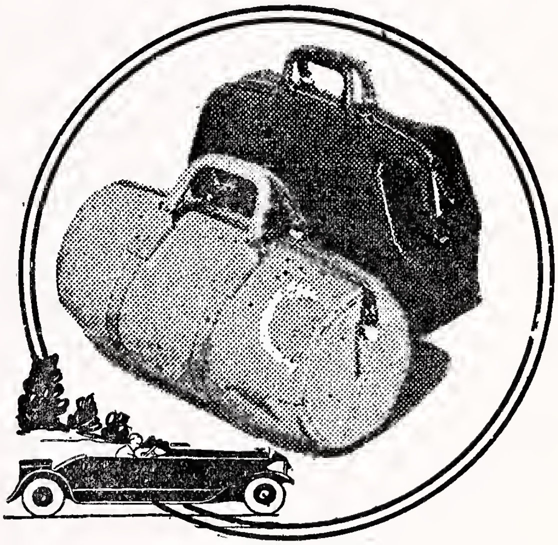
The Mid-South Post-Graduate Medical Assembly was a great success this year considering the "time". The registration reached nine hundred and eight nine. The entertainment was very fine. The program was extra good and up to the standard. The Mid-South is in a class to itself. It covers the field of medicine and surgery in a post graduate course by the best authorities in the United States. It has a broadening influence. All come together in one assembly room. The essayist is given one hour and he covers his subject. At the luncheons any one may ask any question and have it answered or discussed. We do not know of any other assocition that offers so much by the auhtorities in such a short time, and for so little expense. The regular meeting place at the Peabody Hotel is wonderfully convenient. This hotel is second to none in service and in arrangement. It has a cordial atmosphere. It furnished good food and, the prices are reasonable. It is well arranaged for the exhibitors, They have been a big factor in making the association what it is. In fact the exhibitors make up a good part of the meeting. They are and should be considered a part of the assembly. We like to see the latest in equipment and in biologicals. The city of Memphis has a fine medical atmosphere. It has able surgeons, practitioners, and specialists. They have a glad hand that is worth your while going to Memphis to shake. Memphis is made up of a people who are friendly, cordial, and cultured. Memphis has a fine medical school. It is most fortunate for the medical profession of the Mid-South that we have such a wonderful opportunity to keep posted as is offered at this Post-Graduate Assembly. And last we want to offer our cordial congratulations to and express our appreciation of the splendid program committee and the efficient secretary, Dr. Cooper.



The old family physicnial, poor in equipment, but rich in mind, heart, and soul, the medical, social, and religious advisors of the entire community.



Dr. Golpher, the super-concentrated specialist, well grounded in sports and society and some of the ailments affecting some small part of the human anatomy. He believes his success is measured by the size of the fees he is able to extract.



The broadly educated, cultured, refined, and professionally trained general practitioner and general surgeon, "one man," with his car, kit, and clinic and hospital around the corner who is now well equipped in every way to take care of nine tenths of the cases he sees. He sprung from the old family physician. He is now the specially trained general practitioner and has, or will become the corner stone of the medical profession.

The Medical and Surgical Treatment of Gall Bladder Disease

BY THOMAS R. BROWN, M.D.
Balitmore, Md.

It is very interesting to think how completely our attitude toward the gall bladder has changed during the past twenty years—twenty years in which I have devoted the major portion of my time to the study of digestive problems and have therefore had an opportunity to study this question at close range. Two decades ago diseases of the gall bladder were supposed to be relatively rare—quite a few cases of gallstone colic, a very few of empyema and hydrops, occasionally neoplasm, almost comprised the story—though the surgeons now tell us that a large proportion, certainly over one-half of the gall bladders in people of middle or later life, are diseased to a greater or lesser extent.

Moynihan has taught us of the enormous role it plays in cases which before that time were diagnosed as purely functional dyspepsias; Lyon has given us a method, which, while by no means as valuable a diagnostic aid as many have thought, nevertheless is a real aid in recognized certain cases of infection of the biliary tract; Graham has furnished us with a radiographic procedure which has enormously widened our diagnostic field; while the clinician, spurred on by these contributions from the fields of surgery, laboratory technic and radiology, has restudied the problem and has now a far better knowledge of the clinical picture presented by the diseased gall bladder with a corresponding improvement in treatment, be it medical or surgical.

There are still many gaps in our knowledge; there are still many fundamental problems in etiology that have not been solved; diagnosis cannot always be made either as to whether there is gall bladder disease or not, or if there is disease, its exact nature or intensity; but enough has been done for us to be able to broadly evaluate the diagnostic criteria, the nature of the various forms of therapy and the probable results of that therapy.

It is a consideration of these principles as to etiology, diagnosis and therapy based on this newer knowledge and a rather extensive experience in this field that is the reason for this paper, that is: How to answer the questions—

First: Has the patient gall bladder trouble, and if so, what is its nature and severity?

And second: With gall bladder disease certain or probable, what is the proper treatmnet?

In the first place we must entirely change our attitude toward the gall bladder. We cannot regard it as a definite entity such as the heart or the kidney or the eye. It must be considered as part of a system—Liver, extra hepatic and intra hepatic biliary ducts, gall bladder itself—because when gall bladder disease is present there is usually a greater or lesser concomitant and associated pathology in the rest of this system. Thus the result of our therapy, notably our surgical therapy, will be largely dependent upon whether this associated involvement of liver and biliary system is great or small; whether the major

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portion of the pathology will have been removed by the attack on the gall bladder; whether the compensatory dilatation of the biliary ducts and radicles following cholecystectomy will take care of the associated hepatitis or cholangeitis; or whether in reality it is liver and biliary tract that play the larger role in the syndrome presented and that represent the primary trouble, and the gall bladder is playing only a minor and secondary role.

For this viewpoint, this consideration of liver and entire biliary system rather than gall bladder alone, we have sound embryological, anatomical and physiological, as well as clinical, justification.

The liver and gall bladder are developed together from the first evagination or bud that springs from the gut; the solid cephalic portion of this bud giving rise to the liver—the hollow caudal part continuous with the lumen of the gut giving rise to the extra hepatic ducts, with the distal portion enlarging to form the gall gladder. Thus the embryological evidence of their homegeneity!

The gall bladder, although in the main covered by peritoneum, is connected with the liver in a portion of its superior surface by areolar tissue containing lymphatics and blood vessels through which, obviously, infection may flow in either direction. This, with similarity in blood and nerve supply, the anatomical basis. Occasionally, of course, the gall bladder is entirely covered by peritoneum, is not directly connected with the liver, but is dependent from it by pure peritoneal attachment which may very occasionally become elongated to such an extent that the gall bladder may be situated in the lower right quadrant of the abdomen and produce a tumor very difficult or impossible to diagnose. I saw such a case last year which, incidentally, was only correctly diagnosed at operation. The proximity of the gall bladder to liver, to transverse colon, duodenum and pylorus, is the obvious cause of the confusing symptoms so often presented, especially as it may vary somewhat in position, may even be to the left of the median line and may show certain anatomical abnormalities such as congenital communication between hepatic and cystic ducts or separate openings of hepatic and common ducts into the duodenum; and extremely rarely there may be a double gall bladder. Another factor of extreme interest in the consideration of the association of diseases and the confusing over-lapping of symptoms in biliary tract disease, is the position of biliary and pancreatic ducts, incidentally very closely connected anatomically in their fusion in the duodenal wall, in about 96% just before the papilla of Vater, though in about 4% of the cases fusion is seven centimeters higher, which by some has been supposed to be the cause of pancreatic lesions, notably an acute pancreatitis secondary to gall bladder disease.

Physiologically, of course, liver, biliary tract and gall bladder must be considered together. It will take us too far afield to go into the complex subject of liver physiology, but in one of its many functions, the formation of bile, the role of the gall bladder is now fairly well understood. The work of Rous on dogs has shown that its major function, at least, is the concentration of the bile. The fact that he showed a variation in concentration power in normal

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animals from three to eleven times (possibly partly based upon anatomical variations) must make one a bit skeptical as to the diagnostic value of faint gall bladder shadows after dye administration as evidence of pathology. May not some of these be simply variations in concentrating power?

As to the motor mechanism of the gall bladder, there is still much difference of opinion. Although many do not believe it, the weight of evidence seems in favor of a true sphincter, the sphincter of Oddi. On the other hand, the weight of evidence seems to be against the view that muscular contractions of the gall bladder wall play a significant role in its emptying, the absence of such a mechanism having been recently shown very beautifully by Marrazzi, who studied the gall bladder by direct observation through an endoscope and who showed definitely that neither under ordinary physiological influences nor after the use of drugs that have a definite effect on smooth muscle elsewhere, nor by mechanical or electrical stimulation could such contraction be demonstrated.

As to the role played by the gall bladder in the formation of cholesterin, here again we meet widely divergent views. The evidence, however, seems to be most in favor of the view that the gall bladder absorbs cholesterin as supported by Aschoff rather than that there is any secretion of cholesterin by the wall itself. In fact, there is increasing evidence that the intake of lipids by mouth plays little or no role in cholesterin metabolism. There is, therefore, little evidence in favor of excluding oils, eggs, cream and other fats from the diet of those with cholelithiasis except, obviously, in cases which are associated with jaundice where the reason of course for such exclusion from the diet is the well known deficient digestion of fats in the absence of bile in the intestine.

ETIOLOGY

In regard to the etiology of biliary tract disease, something is known, a great deal is still unknown. There seems to be evidence that overeating, a sedentary life, lack of exercise and obesity all in a way predispose to it. There is a fairly general belief that pregnancy and the puerperium play a role; that many cases date their first definite symptoms—severe pain, jaundice, upper right quadrant discomfort—from the last days of pregnancy and the first days of the puerperium, the attacks often forgotten in the lapse of time and only elicited by careful history that is so essential in the unraveling of all abdominal cases.

On the other hand, some observers are quite convinced that gall bladder pathology is relatively not more frequent in women that have borne children than in those who have not, although personally, I can hardly escape from the belief that in some cases there is definite connection, possibly due to inactivity, possibly to pressure, possibly to disturbed blood chemistry, or possibly to infection.

Preceding infections, notably typhoid fever, unquestionably play a role in some cases. The typhoid bacilli presumably pass from the intestine by way of the mesenteric glands, Lympahtics, and thoracic duct into the general circulation, and in their excretion by the bile may be so concentrated in the gall bladder as to produce temporary or permanent pathology—cholecystitis or cholelithiasis. This, however, occurs far less frequently than was formerly supposed; in our experience not more than 5 per cent of the cases of cholelithiasis seem to be of this orgin, but certain of these cases living typhoid bacilli may still be obtained in the bile and from the center of the stone, although the infection had occured many years ago. It is this type of case, as well as the so much commoner similar urinary tract typhoid infections, that is such a menace as a carrier. Other infections, notably influenza, may play a similar role, through the path of infection may be somewhat different.

Cardiac disease unquestionably predisposes to cholelithiasis, probably due to the inevitable inacttivity of the patient, the passive congestion of the liver, the disturbance of digestive function with its usual absence of gastric acid and the corresponding increase in the gastric and duodenal bacterial flora. Thus in the royal infirmary at Manchester, gallstones were present in 10.4 per cent of 504 cases with cardiac pathology and in only 5.1 per cent of cases with no such pathology. On the other hand, the reverse is equally true—that definite myocardial changes may be referable to biliary tract disease with its pain, its fever, its jaundice, its excess of bile salts, pigments and possibly other toxins in the blood.

Cholesterin stones, the so-called metabolic stones, may possibly be due to excessive cholesterin in the blood, but it is far more likely they are due to certain changes in the bile lessening the solubility of this substance of lowering the absorptive power of the gall bladder wall.

There are many precancerous lesions in the digestive tract—leukoplakia, peptic ulcer, intestinal polyps—but none more interesting than the role of cholelithiasis in the origin of gall bladder cancer, 70 percent of those dying with this disease having gallstones as well.

Cirrhosis of the liver certainly predisposes to biliary tract and gall bladder disease; probably by direct infection, possibly by disturbances in bile formation; while the role of the liver in cholelithiasis is well shown by the not infrequent association of hepatic and gall bladder lithiasis and the development of stones in the hepatic biliary system after cholecystectomy.

On the other hand, the vast majority of diseases of the biliary tract cannot be explained by any of these factors; they must have their origin in an infection from the gastro-intestinal tract, but whether the lower portion of this tract—the colon, the appendix, the terminal ileum—or the duodenum plays the larger primary role, is still a moot question.

In regard to the duodenum, it is worth remembering that while under normal conditions stomach and duodenum are practically sterile, in any condition which leads to gastric or duodenal inflammation, especially, as is the case of most, with a temporary or permanent absence or diminution of hydrochloric acid in the gastric contents, the duodenum is filled with all forms of intestinal micro-organisms, notably the colon bacilli, (although of course streptococci are also met with as they are markedly prevalent in the ileum under normal conditions and in smaller proportion in the colon.) It is highly probable that this group of organisms is in the majority of cases the cause of infection of gall bladder, liver and biliary tract, acute and chronic cholecystitis, empyema, gangrene and suppuration. It is amazing how rapidly colon bacilli may appear in the duodenum in such conditions, as for instance following an acute gastritis which is usually associated with a temporary achlorhydria.

The path of infection of this organism from intestinal tract to biliary system is still a moot question. It is certainly not proven that its path is similar to that of the typhoid bacillus, that is, through mesenteric glands, lymphatics, thoracic duct and general circulation. It is possible that this path is the portal system, but there is very little experimental evidence for this. It might be through the lymphatics directly to liver, producing first a liver infection and thence by the lymphatic system between liver and gall bladder into the gall bladder as a secondary infection, as Graham and many others believe; although many others think the reverse is more probable, that is, the gall bladder is primarily, the liver secondarily, infected. It may represent an ascending or retrograde infection from the diseased duodenum and this view is held by a number of investigators, the lesion in this case being first superficial and relatively easy to cure, later invading the gall bladder wall and obviously much more resistant to treatment.

The frequent association of duodenitis and gastric disturbances with gall bladder pathology, speaks in favor of the latter of these views, while perhaps the even more frequent association of gall bladder disease and appendicitis is more in favor of a direct lymphatic infection from the lower intestine. There is quite a little experimental evidence in favor of this but perhaps not more than experimental evidence in favor of other views.

Some still believe with Rosenow that many cases of biliary tract disease are due to special strains of streptococci coming from periapical abscesses and diseased tonsils or accessory sinuses directly through the blood stream, that is, by the cystic artery; but while it is possible that this may play a role in some of the severer cases where virulent streptococci are found in the throat and also in the gall bladder, it is highly improbable that it plays a large role in chronic infections. Many observers have not been able to confirm Rosenow's work and according to some of these not more than 7% of the organisms found in the diseased gall bladder are streptococci, the vast majority being colon bacilli.

Finally, one must not forget the possibility that anatomic abnormalities—kinking of the ducts, abnormal position of the gall bladder and a physiologic variation in the concentrating power of this viscus —may play a contributory role.

SYMPTOMATOLOGY

The symptoms in gall bladder disease may be definite, localized, and crystal clear; or they may be diffuse, referred elsewhere, blurred and indefinite. No cases are easier to diagnose than the former, none more difficult than the latter.

Nothing could be more clear cut than the typical gallstone colic with or without jaundice; the localized, agonizing pain requiring morphine, the tenderness, the nausea, the epigastric distention, often a white stool and dark urine give a picture almost impossible to mistake. Yet we have all had cases where with such a history gallstones have not been found, but either cholecystitis alone (and of course in this event there may have been a single stone which had been passed) or no evident disease there but a renal calculus or pyelitis or spastic colon with mucous colitis, a diseased appendix, a duodenal ulcer, evidence of upper right quadrant adhesions or absolutely no evidence whatsoever of any pathology where the symptoms were presumably due to coronary disease, non demonstrable arthritis of the spine, a localized neuritis, a gastric crisis of a locomotor ataxia, or simply a localized manifestation of hysteria or psychoneurosis.

Again, it is hard to mistake an acute cholecystitis with its local tenderness, often exquisite, its fever, its nausea, possibly its slight jaundice, its leucocytosis, and often its palpable tumor. And yet again, it is extremely difficult to eliminate certain rare other possibilities and in certain cases to differentiate a mild infection which will clear up spontaneously from a severe suppurative or gangrenous process. In the latter case in most instances, the infection will be kept from becoming a general peritonitis by the enfolding arms of the ever-protective omentum, one of whose main functions is the localizing of infection. Yet, in certain cases, this mechanism may not be effective and immediate surgery may be necessary to save life. It is for this reason that an ever increasing number of surgeons believe that the acute gall bladder should be treated exactly as the acute appendix; that is, by immediate surgery; although many still believe that in the vast majority of cases it is wiser to wait for the infection to quiet down with subsequent interval operation if necessary. Unquestionably in many cases the severity of the infection can be determined by careful clinical observation, the study of temperature chart, the frequent estimation of total and differential leucocyte count, the presence or absence of sweats, the variations in the pulse, the general condition of the patient, the evidence of toxemia; but there are certainly some cases in which suppuration or gangrene may develop with no local, general or laboratory findings that would arouse any suspicion as to its possibility.

Mentzer, in his recent very careful review of all the gall bladder operations in the San Francisco Hospital from 1919 to 1931, is convinced that . . . "advanced acute cholecystitis cannot be recognized in many instances even by the ablest physicians; that what appears to be a mild or moderately severe cholecystitic inflammation clinically may actually be fulminant and that perforation and gangrene of the gall bladder occur more frequently than is usually suppose."

I have recently seen several such cases and personally believe that for some reason there has been a definite increase of these fulminating cases in the past few years. In two of my cases it seemed to follow immediately after an attack of grippe with bronchial pneumonia, but whether this was the real cause one cannot say.

Thus, while in gallstone colic and in many cases of infected gall bladders the symptoms are fairly definite and the diagnosis easy, nothing is more difficult than the diagnosis of disease of the biliary tract in that large group of chronic, and small group of acute, cases, where there are few or indefinite local symptoms, and almost entirely symptoms referred elsewhere. The reason for this referring or overlapping of symptoms is easily understood when we think of the close juxtaposition of liver and gall gladder, heart, lungs, stomach, duodenum and transverse colon, when we remember the great similarity in blood and nerve supply of these viscera and realize with Charles Mayo . . . "How diverse may be the paths through which painful sensations may leave the abdomen." (Many, however, still believe it is a viscero-sensory reflex and not the presence of true nerve fibres that explains such phenomena.)

A pain in the right shoulder or a persistent backache usually in the right side may be the only evidence of biliary tract disease—the former probably due to the fact that a branch of the phrenic nerve unites with the sympathetic fibres of the celiac plexus to form the phrenic plexus. The picture may absolutely stimulate duodenal ulcer—hunger pain, periodicity, persistent defect in the X-ray plate, even extensive hemorrhage—and yet a normal duodenum but a diseased gall gladder be found at operation; while the reverse is also true, that is an ulcer in the second portion of the duodenum presenting only a typical gall bladder syndrome. In trying to determine the cause of extensive hemorrhage, one should never forget the possible role that an unsuspected gall bladder may play, probably due to an associated marked engorgement of the veins in stomach or duodenum; while it is wise to remember that even a diseased appendix may also be associated with severe hemorrhage. It is, however, well to remember that the association of ulcer or appendicitis and gall bladder disease is not at all uncommon.

A diseased gall bladder with its achlorhydria, the anorexia and loss of weight met with in certain of these cases with a persistent filling defect in the stomach, which may be due to adhesions between gall bladder and pylorus. may so completely simulate gastric carcinoma that only at operation the mistake is discovered.

In a few. fortunately a very few, cases the symptoms may be entirely cardiac—usually simulating coronary disease, occasionally myocardial weakness—but where there is no such disease but only a group of symptoms reflexly produced from a disease gall bladder. We have recently reported a group of such cases where all the cardiac symptoms disappeared after cholecystectomy, but we must never forget that the reverse of the picture—that is, coronary disease with exclusively abdominal symptoms usually suggesting gallstone colic—are far more common. One must therefore be very sure and very careful before diagnosing a cardiac syndrome as biliary in origin and advising cholecystectomy as its treatment.

These are the **uncommon** referred symptoms of gall bladder disease. Much more commonly of course the symptoms are referred to the stomach. It is certainly true that a large number of the flatulent dyspepsias met with mostly in women, but occasionally in men, of middle life, with discomfort and distention after meals, marked discomfort during the night, fulness, eructation, palpitation, and sometimes slight nausea, are due to an unrecognized gall bladder disease with or without stones. The discomfort sometimes radiates to the ball bladder region, there is sometimes local tenderness on deep pressnre, but often there is no suggestion of any gall bladder pathology and this gastric syndrome may be the only evidence of cholelithiasis or cholecystitis. Sometimes on close questioning the history of an acute attack may be elicited; more often there has been no definite biliary tract history. It is sufficiently common to be dignified by the name of biliary dyspepsia; it should always be suspected as a potential cause of atonic flatulent dyspepsia, especially if the symptoms are much more marked at night.

In certain cases of diabetes gall bladder pathology is found without antecedent history and in certain cases with definite history of previous attacks. It is unquestionably true that biliary tract pathology, recognized or unrecognized, is present in a certain percentage of cases, varying from the 1% of Nauyn to the 41% of Eustis. Sometimes slight persistent of periodic fever may be the only sign, while there is still a considerable group of physicians notably Wilkie who believe that a diseased gall bladder is a very potential factor as a focus of infection in various widely different conditions — arthritis, nephritis, myocarditis and other chronic inflammatory processes.

I, personally, have seen very few cases in which such a relationship can be definitely proven. I have many times been extremely disappointed in the absence of any benefit after cholecystectomy and I am extremely skeptical as to the advisability of gall bladder removal as a proper treatment in such cases. I hardly remember a case that has been very materially helped thereby. (On the other hand, it is perfectly true that fever, toxemia or jaundice of a long lasting biliary tract infection may possibly be the cause of trouble elsewhere and it seems quite definitely proven that myocardial disease can be produced by this mechanism.)

It is a disturbing organ, this gall bladder, with its localized symptoms in one case, its referred symptoms in another, its mimicry of disease elsewhere and its ability to mirror disease in other organs. To make the maximum number of correct diagnoses and to minimize failures, all the possibilities that we have briefly sketched above must be carefully considered and weighed, for it is by this knowledge, combined with the proper examination and the appropriate laboratory studies, that we must hope to reach the correct diagnosis.

DIAGNOSIS

How then may we best arrive at a correct or at least a probable diagnosis? In my experience the very best information comes from an old fashioned procedure, far too often forgotten in the passion for short cuts to knowledge by laboratory or objective methods—the history of the case! I have found that notwithstanding the notable advances made in X-ray diagnosis, in the study of duodenal contents, and in other technical methods which are always increasing our already very large debt to the Roentgenologist, the research worker and the technician, it is from a carefully taken, thorough and well digested history of the case, the noting of the mode of onset, the early symptoms, the change of symptoms, the picture as it progresses and the various factors that modify it, from which we can obtain the most reliable diagnostic data.

The history, sometimes almost forgotten, of a severe attack or attacks of right epigastric or hypochondriac pain requiring morphia hypodermically for its relief, the story of attacks with jaundice and slight rise in temperature, of acholic stool and cholic urine, of persistent or remittent pain or tenderness in the upper right quadrant, or of nocturnal flatulent gastric dyspepsia,—it is from these we often make our final diagnosis and plan our treatment, never forgetting, however, in the wise words of Professor Haldane that in studying biological phenomena. . . "We must always keep the whole organism in view." It is of singular importance in this field where the symptoms are so often difficult to interpret.

In a careful analysis of the large amount of material in our Clinic two years ago, we found that by such a method alone, that is, careful analysis of the history, not only digestive history but the entire history of the patient with the usual routine physical examination, slightly less than 85% correct diagnoses were made in cases of biliary tract disease as judged by the subsequent history of the cases—usually surgical.

Next in value, of course, is cholecystography by the Graham method. But our experience has been that by this method alone the chance of error is a little greater than by the preceding method alone, if judged by the same criteria. In our series we have found both a positive and negative error of about 20%; in other words about 20% of the cases diagnosed as pathological were found to be normal and about 20% of those diagnosed as normal were found to be pathological. We, however, have used practically exclusively the oral method and the margin of error is certainly somewhat greater by this than after the intravenous administration of the dye. It is needless to say that in all suspected cases one should never be satisfied with one series of plates alone. But as we have already mentioned, variation in the concentrating power of the gall bladder and of the absorptive power of the intestinal mucosa and probably anatomical variations as well in the normal gall bladder, must per se produce variations in density of shadow that are likely to be regarded as pathological, but that may in reality be within normal limits.

In the case of the diagnosis of gallstones by cholecystography, the possibility of error is of course very much greater, some saying that as many as 50% of subsequently demonstrable gallstones have not been visualized in the X-ray pictures.

As to the value of the so-called medical drainage of the gall bladder (method of Lyon) as a diagnostic procedure, there is the widest divergence of opinion. Some place the utmost confidence in it, others deny its value altogether. Personally I do not use it as a routine measure mainly because with the tendency to subacidity and achlorhydria so common in biliary tract disease, the normal sterile duodenum teems with all kinds of bacteria and therefore bacteriological studies seem to me of little or no value except in those rare instances where very unusual micro-organisms or some form of protozoa, such as Lamblia, are found in large amounts; the presence of a few pus cells cannot be of much significance because of their possible origin from pharynx, stomach or duodenum, while, in our experience at least, the presence of cholesterin or bilirubin calcium crystals is not diagnostic of gallstones and are frequently found when no such pathology is present.

On the other hand, I have found it of great value in certain cases, mostly those of extensive associated hepatitis and biliary tract infection. It is useful in this group of cases both before and after cholecystectomy, especially in the latter instance and in this case it often tells one what nothing else can. These cases are relatively rare, but they are very important for if we can realize the extensive involvement of the entire biliary tract before operative procedure has been considered, we may either decide to postpone operation longer, or, instead of the usual cholecystectomy, to advise cholecystostomy with its long period of drainage or cholecystgastrostomy.

These, with the physical examination and the ordinary laboratory procedures, study of blood and urine, etc., are our main means of diagnosis. But there are other methods which sometimes help,—the study of local areas of hyperasthesia, frontal or dorsal pain points, the estimation of pancreatic ferments in the duodenal contents to see if we can get evidence of any associated pancreatitis, the estimation of bile acids in drainage material, some having suggested they are diminished in calculus cholecystitis but not in inflammation without stone. Possibly of much greater use are functional liver tests, for as Graham, McComb, Jackson and others have preached, every cholecystitis with or without stone is associated with inflammation of the liver—mild, moderate or severe. In the latter cases at least this may be far more the cause of symptoms than the gall bladder itself.

In regard to tests of liver function, many tests have been suggested for the liver is very protein in its activities, bile forming, glycogenic, antitoxic, in addition to the role it plays in fat and protein metabolism. To really visualize the liver's condition, theoretically at least, tests based on each of these functions should be utilized.

Unfortunately, few of these tests are really satisfactory, few are very accurate; but of the most used tests, each of them may help us a little in certain cases. In our experience, however, in most instances this is often very little, though the galactose test is probably of more value than the van den Bergh, icteric index, bromsulphalein, urobilinogen or estimation of dye retention after cholecystography by the Graham intravenous method.

It is a great pity that we cannot know better the state of the liver in this group of cases and therefore plan better preoperative and post-operative treatment, for after operations upon the gall bladder, if death occurs, it is usually not post-operative pneumonia nor general peritonitis that is the cause, but hepatic insufficiency.

With the utilization of all the diagnostic methods at our command, history, physical examination, various laboratory procedures, and cholecystography, we believe we should be able to make a correct diagnosis both as to the presence or absence of pathology as well as its nature and degree in about 90% of the cases.

TREATMENT

After the diagnosis has been made, what is the proper method or treatment? Is surgical or non-surgical therapy indicated? And if surgery is decided upon, what is the operation of choice? What are the chances by the various methods of cure or relief? What is the percentage of failures and what are the possible complications?

There is an ever increasing feeling that in the treatment of diseased gall bladders, surgery has been disappointing in a number of cases. Is this feeling justified, and if so what is the cause of it?

To my mind there is no question that in the very definite, very severe lesions of the gall bladder—suppuration, gangrene, perforation, stone—where frequent or severe attacks of gallstone colic take place, surgery is the only procedure to consider. Whether, in the former group, to operate during the acute stage, doing a cholecystectomy if possible, whether to wait until that state is over, confident that even if perforation does occur, the omentum will prevent general peritoneal infection, is still a moot question. Graham, for instance, "has not advised an operation on an acute gall bladder for four years and except for the finding of an occasional pericholecystic abscess, which probably represents the perforation of an acutely inflamed gall bladder, has seen only two cases of perforation causing general peritonitis."

Mentzer, on the other hand, says "perforations on the upper aspect of the gall bladder and those that are immediately walled off by the omentum may be operated upon later, but in the present state of our knowledge we apparently cannot diagnose a case of perforation from a gangrene or acute empyema." . . and he, therefore, advises immediate operation.

Most surgeons agree with the former view, a smaller but increasing number with the latter view. When surgeons differ, what is a mere clinician to believe and to advise? Is it safer to operate or not operate immediately on these cases? Are they to be regarded as emergency or semi-emergency operations or as cases where it is wiser to wait until the acute process has subsided, (and most of these cases I believe will subside) or is immediate operation indicated?

I feel quite sure that a few cases unquestionably need immediate surgery. I feel equally sure that for no reason that I have been able to determine, this group of cases is increasing, but how to determine this relatively small group, that is the rub! On the other hand, I believe that by a thorough analysis of every case, by having no fixed general rule, by regarding each as an idividual problem, by weighing all the factors—the general condition of the patient, the leucocyte count, especially the differential count, the temperature chart, the examination of blood and urine, and intensive clinical study of the patient, we can usually, although not always, decide whether the case is subsiding or becoming progressively worse.

There is of course no question in my mind that in the latter group immediate operation is indicated. In the former group, I feel equally sure mortality is likely to be lowered by performing an interval operation after the acute inflammation has subsided. (We must, however, not forget that the symptoms and signs of these cases may occasionally be so slight that gangrene and perforation may take place with very slight local, and no very striking general, signs or symptoms.)

As to the prognosis in cases of operations on the gall bladder, even in those with symptoms of severe infection, it is usually good, and if they weather successfully the immediate operative and post operative dangers, their subsequent condition is usually excellent. It is rather a wise rule to remember that in abdominal surgery the more severe the symptoms, the more definite the diagnosis and the more obvious the surgical need, the better the results obtained.

In the chronic cases of cholecystitis, with or without stones, when the symptoms are not fulminating or acute, when the attacks are not severe or frequent, what should be our attitude as regards treatment? Does surgical or non surgical treatment offer the best prognosis? Should we accept the view of certain surgeons and say every diseased gall bladder should be removed as early as possible because by so doing a potential focus of infectiin will have been removed, the associated hepatitis and biliary tract infection will usually quickly subside, it will minimize the possibility of secondary lesions—pancreatitis, diabetes, persistent functional dyspepsia—and the possibility of malignant degeneration will be reduced to a minimum? Or should one say it is in just this group of cases that operation should be postponed indefinitely, if possible, because the dangers of waiting are far outweighed by the possible or probable post operative sequelae? What are these possible sequelae? Post operative adhesions, a common duct stone, possibly somtimes pushed down into the common duct during the manipulation of operation, and either of these often absolutely reproducing the original syndrome or producing a new syndrome often as bad, such as periodic attacks of greater or lesser obstruction or periodic attacks of biliary tract infection or even persistent low grade biliary tract disease, producing symptoms sometimes more severe than the original picture; the fact that the functional disturbances often remain after gall bladder removal and have become so well established that they, not the underlying pathology, dominate the picture, or to a fundamental misconception of certain of these cases which in reality present symptoms far more referable to diseased liver and biliary tract than to the gall bladder alone, the gall bladder playing but a minor role. Here its removal, even with the compensatory biliary tract dilatation, often brings about no benefit and often real harm by the effect of post operative adhesions. Perhaps even more important still is the fact that we have removed a crutch on which we may have to lean heavily if the infection of liver and biliary tract does not subside.

It is an argument in favor of cholecystostomy in certain of this group of cases rather than cholecystectomy, because, if the better drainage from cholecystostomy does not clear up the picture, the gall bladder may then be anastomosed to the stomach to bring about free permanent drainage, a far wiser and safer procedure than a long drainage through a densely tied up common duct by means of ordinary catheter or T tube or by an attempt to establish a fistula and then transplant it into the stomach. It seems to me a very wise rule to consider long before cholecystectomies are done when there is very marked evidence of hepatitis or of extensive infection of the rest of the biliary tree. Of course I am sure cholecystectomy is by far the best operation in the vast majority of cases. I am equally sure it is the worst operation in that small group where there is evidence of extensive disease of liver and biliary tract as well.

These cases, quite frankly, are not treated with especial success by medical measures and I should personally feel far safer if first a cholecystostomy were done to see the effect of its long free drainage or even to do an immediate cholecystogastrostomy so as to bring about permanent drainage.

I feel very strongly that in the case of chronic cholecystitis, unless the operative indication seems very definite, especially if the picture is blurred and the symptoms indefinite and where we lay our diagnosis more on the altar of cholecystography than on that of symptomatology and in cases where there is evidence that the symptoms are increased by an unstable psyche, it is wiser to postpone operation sometimes indefinitely, sometimes until we have definitely proven that all other measures are ineffective.

In this group of cases, what medical measures can we offer? What is their chance of relieving the symptoms in whole or in part, in bringing about a clinical cure even if not an anatomical cure, because of course no medical measures can dissolve gallstones, cause adhesions to diseappear or make new a mucous membrane or bladder wall that has been chronically thickened by disease? What are the principles of the medical treatment of these cases? What can it hope to do? Is it likely to be successful in a considerable proportion of the cases? Can it produce a clinical cure in many cases? Can it relieve a number so that the patient is relatively well? Will it be so effective that fever or jaundice or evidences of periodic common duct obstruction or attacks of gallstone colic will not recur? Or, if they do, will they be of so much less intensity and severity and at so much longer intervals that the patient is satisfied? Will the underlying pathology be improved or at least not progressive? As I see it, our two main objects in medical treatment are—first, to minimize the chances of reinfection of biliary tract; and second, to promote free biliary drainage. The first is brought about by keeping mouth, teeth, tonsils and sinuses in as perfect condition as possible; by avoiding in the diet mechanical, chemical or thermic irritants, highly seasoned foods, rich foods, excessively coarse foods, and probably alcohol in most cases, so that the chance of gastritis and duodenitis is reduced to an irreducible minimum, and to avoid constipation or diarrhoea so that there is a minimal chance of infection from the colon.

The weight of evidence is certainly in favor of the lower bowel playing a considerable role in these cases and some believe that there is rarely gall gladder infection without a preceding colitis. In the majority of cases, appropriate diet with large amounts of the softer fruits and greens, the elimination of astringent foods, and the installation of a regular habit is all that is necessary, with, of course, the general hygienic measures so necessary to every bodily function—plenty of sleep, a normal amount of exercise, fresh air and play, and as much freedom from worry as is possible in this vale of tears. In many cases, this is all that is necessary, but in some laxatives have to be used as well. It is unquestionably true that the vast majority of cases with recurrence of symptoms in biliary tract disease are due to reinfection and it is therefore essential to minimize this possibility by every means at our command. There is, however, very little evidence that specific disinfection of the gall bladder or biliary tract, as Hurst has suggested by the use of methenamine, is possible for although the drug is eliminated in the bile, it is in such a minimal amount and so much diluted as to make me feel that it cannot have an appreciable bactericidal effect.

As to the second requisite in treatment, the promotion of free biliary drainage, we have many means at our command but none so good as that method most physiologic of all—the utilization of the normal gall bladder emptying by the intake of food. Frequent feedings, a proper non-irritating diet, with large amounts of those substances especially effective in emptying the gall bladder, such as butter, cream, olive oil and especially egg yolk, these foods to be given in large amounts even if gallstones are present for the evidence is distinctly against their playing any definite role in gallstone formation. In my experience the only justification for their elimination is when jaundice is present. This is the fundamental dietetic procedure. It is really quite remarkable how often olive oil before meals or on waking, or one or two raw eggs at night will bring about a rapid emptying of the gall bladder and often act as a gentle laxative as well. We use these foods in cholecystography; why be afraid of them in our treatment of disease?

All the salines help—a morning dose of phosphate of soda, magnesium sulphate, the Bourget mixture, ordinary table salt or lemon juice and soda, or perhaps better still a smaller dose shortly before each of the three meals, given preferably in hot water, is often singularly effective. It is well to remember that magnesium sulphate is not a specific, is not sacrosanct, that all salines have the same effect to a greater or lesser degree. One should also not forget that magnesium sulphate by mouth in capsules or in saturated solution, is just as effective a cholagogue as when administered through that most unphysiologic of instruments, the duodenal tube. It may be good psychotherapy to use it in certain cases; it certainly is not indicated as a physical agent and I for one prefer to give my suggestive treatment, if that seems necessary, by more rational, less expensive and less time consuming methods.

These are our two main methods of attack, and while in certain cases antispasmodics such as belladonna, or mild sedatives such as luminal or the bromides, or hydrochloric acid if the gastric acid is absent, may help, it is upon these two procedures that we must place our main reliance. How many cases can we help by these methods? Few, if any, of the fulminating or acute lesions, a fair proportion of cases with gallstone colic, a large number of cases of chronic cholecystitis with or without stone. How large a percentage of success in this large group? We cannot say, for it is practically impossible in the proportion of cases so treated to determine how many helped greatly, how many have been cured clinically, or how many have been complete failures. I have a feeling, however, that a very large proportion of cases may be helped by such a method of treatment if the patient is willing to follow the treatment in principle for a long period of time, perhaps even indefinitely. In my own practice I have a large number of patients who have been comfortable and symptom-free for a long period of time by such procedures alone; even in cases with demonstrable stones or with definite evidence from an X-ray viewpoint at least of considerable gall bladder pathology; cases in which there is no evidence of any progressive damage being done to liver, biliary tract, gall bladder or pancreas by such an expectant therapy and where for long periods of time there has been no recurrence of acute or subacute infection, enlargement of the liver or of any other findings to suggest any damage to liver function. But to repeat, here as in any case of chronic disease elsewhere, the patients must follow certain general directions as regards diet and personal hygiene if they hope to remain symptom-free.

What is the percentage of cures of these cases that are treated surgically? Ask the surgeon and he will tell you from 85% to even 90% or more. But this, I am sure, is far too high, for the surgeon is an incurable optimist; it is often impossible for him to know of his failures, for when there are failures, the patients rarely return to the surgeon for advice but go to an internist or to another surgeon.

In our Clinic at the Johns Hopkins Hospital something more than one-quarter of our operative cases, cases chosen with great care as fit subjects for surgery by a conference of surgeons and clinicians, come back to us complaining of the same symptoms or different symptoms, but complaining! When I was asked a year ago to read this paper, I started on an analysis of the results in 84 cases in my private practice in whom I had advised surgery and where it was possible to find out either by personal query and examination or by the answers to a complete questionnaire as to what the ultimate result of the operation had been. In 63 of these cases, cholecystectomy had been performed; in 13 cholecystostomy; in one cholecystgastrostomy; in one choledochotomy; and in the remainder simply the the separation of adhesions; four had had a cholecystectomy following an earlier cholecystostomy. Four cases died in the hospital, a surgical mortality of 4.7%, which is a little higher than the 3.6% in Eusterman's series of 804 cases. Of the entire series, 65% had had a complete cure, a relative cure or relief from the disagreeable symptoms. But this leaves the rather striking figures of 35% in which operative treatment was unsuccessful. The percentage of success was considerably higher after cholecystectomy than after cholecystostomy.

I, for one, therefore, cannot feel that surgery should be indiscriminately advised for all cases of gall bladder pathology; it has a definite mortality; it has a considerable portion of failures; it has many post operative possibilities which may make the second state of the patient the same as, or even worse than the first.

May I at the risk of repetition again stress my belief? That while in those cases where the clinical picture is a severe one, a very clear cut one, one with very marked local or general symptoms, surgery is the only safe reed upon which to lean; in the milder, less definite and more chronic type of case, it seems better at the present writing to try first the simpler and perhaps safer medical measures. Many of these latter cases remain symptomatically cured if they are willing to follow a certain regimen, not an onerous one; some, and not a negligble portion, may later have to have recourse to surgery either because they get tired of such a regimen or because they do not get sufficient relief from it to make one feel that one is justified in continuing it.

CONCLUSION

In this paper I have tried to bring before you the results of my experience in this field, my credo, if you will, and to ask you to share with me certain beliefs that have through many years gradually crystalized in my mind and which have helped me in my attempt to attack this very difficult problem in the way that is best for patient and for doctor.

I am sure that it is wrong to consider the gall bladder as a separate entity and not as a part of the entire biliary tree, although in a considerable proportion of cases the major portion of the pathology is concentrated there. It is in this group of cases where surgical attack upon the gall bladder is likely to be most successful. I am convinced in analyzing the symptoms we must determine how many are referable to the gall bladder itself, how many to liver, ducts and biliary tract, for on this must rest our decision as to medical or surgical treatment; and if the latter is decided upon, what is the best operative procedure? I am quite sure that, while cholecystectomy is the operation of choice in the vast majority of cases in which surgery is indicated and that in a good many of these cases complete relief may be obtained by the removal of the gall bladder, where there is evidence of extensive liver and biliary tract infection as well, it is far wiser, if surgery is to be done, to employ cholecystostomy, possibly followed later by cholecystectomy or cholecystgastrostomy.

I have touched upon the physiological basis for medical and dietetic treatment; its simplicity and its success in a fair number of chronic cases if carried out conscientiously, but I have tried not to over-emphasize its value because surgery must be utilized in most of the severe and many of the milder cases. Finally, for after all what is the value of treatment if diagnosis is not correct, I have tried to preach the doctrine of thoroughness in reaching one's final conclusions as to the underlying pathology; I have insisted upon the absolute necessity of a careful history of the case as well as the utilization of all the laboratory methods at our command; I have pointed out the difficulties in diagnosis in this field because of the striking tendency of the gall bladder to mirror symptoms due to disease elsewhere and in turn to be the cause of referred symptoms.

To me this will always be a fascinating field, a field beset with many difficulties, a field in which we often must grope rather blindly for a while but one which I feel sure will become easier and easier of exploration if we attack each individual case thoroughly and scientifically, without prejudice and without bias, and if we try to learn as much, or more, from our failures than from our successess.

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An Analysis of the Results of Gall Bladder Surgery

BY T. R. BROWN and JOHN T. HOWARD

On July 15, 1932 the office files of one of us (T. R. B.) contained 84 case records of private patients who had had surgical exploration of the biliary tract at our advice. Needless to say, in all of them gall stones or inflammation of the gallbladder or of the bile ducts was diagnosed before operation; no cases of suspected malignancy, of hepatic cirrhosis, nor cases of abdominal exploration without a fairly definite diagnosis of gall tract disease were included. Operative notes were available on all of these patients. Of these 84 cases who had had preoperative diagnoses of biliary tract disease, such disease was found by the surgeon (and, in most cases, by the pathologist) in all but three of them. But more about the findings at operation later! It is now of interest to glance, briefly, through these history cards to note the soil in which these diseases have thrived and to observe some of the by-effects of their presence in the body.

Of the 84 patients 25 were males and 59 (70.2%) were females. Of the females 35 (59.3%) had borne children and the average number of full term pregnancies in these child-bearing women was 2.6. In only 5, or in 8.4% of all the women, was the onset of symptoms related to pregnancy. 15 (20.0%) of the patients had had typhoid fever. On the records of 9 others this disease was not mentioned and, therefore, we are not certain that they did not have it. The average age of the patients at the time of operation was 47.8 years. The oldest patient was 72 and the youngest was 24. In 80 of the cases the average duration of symptoms prior to surgical treatment was 5.3 years—rather a shorter time, we believe, than one would find in a study of a similar group of dispensary patients. In 4 cases the date of onset of symptoms was very indefinite. A story of jaundice with pain was obtained in the histories of 21 (25.9%) patients. In three histories the presence or absence of jaundice was not noted.

In 50.0% (41) of our cases enlargement of the liver was noted at physical examination. In 2 histories the size of that organ was not mentioned.

The classical hypoacidity of biliary tract disease was not noted in this group of cases from data obtained from a single gastric gavage on each patient forty-five minutes to one hour after an Ewald meal. Records of the gastric acids were obtained in 59 of the 84 cases. Twenty-seven of the 59 had normal gastric acid values (20-40 units of free hydrochloric acid and 40-60 units of total acidity.) Sixteen showed hyperacidity; 9 showed hypoacidity. Achlorhydria to bread and water stimulus was found in 7 cases.

An attempt was made to study the biliary tract roentgenographically in 44 of the 84 patients. In 5 of this group simple roentgenograms only were made of the gallbladder area. In 4 of the 5 gall stones were reported from evidence on the flat plate. In 3 of the 4 the surgeon found gall stones; in the fourth no stones were discovered at operation. The patient in whom stones were not visualized by this method did not have gall stones at operation. Thirty-nine patients of this series had the gallbladder investigated by the dye method. To most patients dye was given orally; to a few it was administered intravenously. The report of a roentgenographically normal gallbladder was received in three cases. In one of these cases an unquestionably normal gallbladder was found and removed at operation. In this case there were many adhestions in the right upper quadrant and to these we ascribed the symptoms. To our recent questionnaire the patient replied that her symptoms had not been benefitted by the operation. In a second case which showed a gallbladder normally filled with dye, gall stones and advanced cholecystitis were found. It must be admitted that the roentgenographic study of this gallbladder preceded the surgeon's cholecystectomy by twelve months. In that period a great deal probably went on in that gallbladder, though the symptoms at the time that the roentgenograms were made were the same symptoms which precipitated surgical intervention. The third case of this roentgenologically normal group was said by the surgeon to have a mild chronic cholecystitis and the gallbladder was removed. The pathological report read, "A normal gallbladder." The dye method of examination showed some abnormality of the gallbladder in 36 patients. Stones were visualized in 19 of the 36. In 18 of this 19 the surgeon found stones. In one stones were not found and the surgeon said that the gallbladder was normal. He did remove it and the pathologist reported "a chronic gallbladder." The patient has reported that he is perfectly well two years after the operation. The roentgenologic diagnosis of gallbladder disease was based on non-filling of that organ in 8 cases. In 5 of these cholecystitis and cholelithiasis were found by the surgeon. In 2 cholecystitis alone was found and in 1 cholecystitis and bile mud were discovered at operation. In this last case cholelithiasis had been diagnosed clinically before operation. In 8 cases the roentgenograms showed no more than a poor concentration of dye in the gallbladder and on this basis alone a pathological gallbladder was suspected by the roentgenologist. Six of the 8 cases showed cholecystitis and stones; 2 cases were found to have cholecystitis only. One patient was operated on without other roentgenologic evidence of biliary tract disease than an irregular contour of the gallbladder. Upper right quadrant adhesions only were found at operation and, in the opinion of the surgeon, the gallbladder was normal. At our insistence the gallbladder was removed and a chronic cholecystitis was reported by the pathologist. Irregular gallbladder contours were noted in 2 other cases in association with more diagnostic roentgenographic evidence of gallbladder disease. In only one of these patients to whom dye had been given was sluggish emptying noted by the roentgenographer. We do not consider the gallbladder's emptying of significance in the decision for or against surgical treatment of gallbladder pathology. Before leaving this topic we may say that a low concentration of dye was often associated with the visualization of stones. We have not mentioned this low concentration where a more important radiographic sign was present.

And now for the findings at operation! Of the 59 cases diagnosed as acute or chronic cholecystitis

WITH gall stones, this diagnosis was completely confirmed in 57. The fifty-eighth case showed gallbladder inflammation with bile "mud," and the fifty-ninth revealed a gallbladder which, to the surgeon, seemed to be normal. Under "medical pressure" he removed the gall sac and the pathologist reported "chronic gallbladder." Cholecystitis alone was diagnosed 25 times and it was found alone in 14 of these cases; it was associated with gall stones in 8. The cholecystitis diagnosed was not found in 3 cases. Adhesions or a mild chronic appendicitis seemed to be the only organic basis for symptoms in 2; a third had a normal gallbladder.

Cholecystectomy was performed 63 times as a primary operation and 4 times after previous cholecystostomy. In this series cholecystostomy was done on 13 patients. Once a cholecystgastrostomy was the operation of choice and once a choledocholithotomy was done for a stone which, presumably, had been overlooked at a previous cholecystectomy. In 2 cases no other surgery was done than the separation of adhesions in the right upper quadrant and the removal of the appendix. Four of the 84 patients died in the hospital of operative or of postoperative complications. This was a surgical mortality rate of 4.7%. The exitus of one was via postoperative ether pneumonia; or another, operative shock; a third develoyed intestinal obstruction and died after a second operation; the fourth developed a bile sinus which eventually communicated with the peritoneal cavity and produced a general peritonitis.

We have attempted to follow the 80 cases who survived operation. Admitting its defects, we have believed the questionnaire method of determining the present condition of these patients to be most practical. We have also had the opportunity of personally questioning and of re-examining a number of the patients in this group. Our questionnaire was similar to that of Catell ( ) of Lahey's Clinic. We asked for replies to the following questions: 1. Have you had complete relief from your gallbladder symptoms? If you have not obtained complete relief, what symptoms have you had? 2. Have you been jaundiced since the gallbladder operation? 3. Do you complain of gas, belching, a feeling of distension or of indigestion? 4. Have you had further operations or X-ray examinations? 5. Have you other abdominal complaints? Eighty questionnaires were mailed. Seven were returned by the postal service because the addresses could not be found. Eight patients were not heard from and 65 returned to us more or less detailed reports about themselves and their symptoms. From these replies and aided by our general knowledge of the patients (every history had a more or less comprehensive note about each patient's nervous state) the cases were classified after the manner of Davis ( ). The first group contained those patients who seemed to be completely cured, i. e., there were left no symptoms to remind the patient of his old trouble. In the second group the patients were relatively cured or had obtained relief from all the more disagreeable symptoms but occasionally they had mild upper abdominal discomfort. The third group was termed improved and contained those patients who still had symptoms but who were decidedly better than they had been before operation. In the fourth group were those not improved by surgical procedure. From the replies to our questionnaire and from our knowledge of the patients we concluded that 28 of the 65 who had answered us had been completely cured by surgery. Ten had been relatively cured; 12 were improved; 13 were not improved; 2 patients had died between the date of their discharge from the hospital and the date of the questionnaire. Answers were received from 49 patients who had had cholecystectomy as their primary operation. Twenty-five (51.0%) of them were unquestionably cured. Six (12.0%) were relatively cured. Nine (18.0%) were improved and 9 were not improved. Nine of the 13 patients who had had cholecystostomy replied to our questions. Two of them seemed to be really cured. Three were relatively cured. Two were improved and 2 were unimproved. Three of the 4 persons who had had cholecystectomy after an earlier cholecystostomy replied. The second operation had completely cured 1; 1 was relatively cured and 1 was unimproved. The patient who had had a cholecystgastrostomy for a pancreatitis associated with a cholecystitis was improved. One patient who had had upper right quadrant adhesions was unimproved by appendectomy and the separation of these adhesions.

From the data in this small series of patients it is again apparent that cholecystectomy is the operation of choice where surgery is indicated for the treatment of cholecystitis with or without stone. With it two patients out of three will receive striking and satisfactory improvement. It is interesting to compare our report of the results of surgical treatment of gallbladder disease with the recent figures published by Judd and Priestley ( ). Their series was a very large one and over 90.0% of their cholecystectomy patients are reported as having secured "a satisfactory result" from the operation. In the same paper they state that "Following cholecystectomy only 17.0% of the patients had any pain in the upper part of the abdomen, and this was usually not accounted for by recurrent biliary lesions." It is quite natural for the surgeons to be charitable to surgery. It is just as natural for the general practitioner and the internist to be critical of surgical treatment, for to them come the disappointments of surgery. Before too high a percentage of cures after surgical treatment of gall tract disease is generally accepted it will be well to have more statistical data on these matters reviewed by medical men.

"I would rather fail in a cause that I know some day will triumph than win in a cause that I know some day will fail."—Woodrow Wilson.

Alexander Graham Bell, a teacher of the deaf and dumb, finally enabled people to talk across hills and valleys.

Andrew Carnegie was once an unknown poverty-striken operative in a factory, who became the most generous and princely of idealists.

Thomas A. Edison was once a newsboy on a train, who became the maker of a thousand wonders.

Combatting the Increasing Death Rate From Diabetes

BY SEALE HARRIS, M. D.
Birmingham, Ala.

Six years ago at the New Orleans Congress of the American College of Physicians Frederick Allen called attention to the increasing death rate from diabetes, even though with insulin and proper dieting deaths from uncomplicated diabetes should be of rare occurrence. A more recent study of America's great medical statistician Frederick L. Hoffman, for many years Chief Statistician of the Prudential Life Insurance Company, shows that the death rate from diabetes continues to increase, "regardless of the insulin treatment and other advances in medicine."

Hoffman's statistics derived from a study of the diabetes mortality rate in 50 cities in the United States show that the diabetes death rate has increased from 15.9 in 1912, to 24.6 in 1931, per 100,000 of population. The total number of deaths from diabetes in these 50 American cities, with a popula tion of 21,244,714 in 1912, was 3,373; while in the same cities, with a total population of 30,987,422 in 1931, the number of deaths was 7,610. The death rates from diabetes in the three largest American cities are inordinately high, i. e. Chicago 27.4, New York City 27.1 and Philadelphia 20.7 per 100,000 of population. No death rates from diabetes in the rural districts have been published; but it is hoped that when the mortuary statistics of the 1930 census appear valuable data regarding the distribution and death rates from diabetes in the various sections of the country may be available. It is believed that there are fewer cases of diabetes in proportion to population in the country than in the cities, but it may be assumed that the diabetes death rates in rural communities are relatively as high as in the cities.

Many causes for the increase in the death rates from diabetes have been suggested. An acual increase in diabetes is thought by some to account for the higher mortality rates from that disease; but probably the most important factor is that, with the feeling of safety which the use of insulin has engendered, diabetics have become more careless in following their diets. The diabetic death rate has not increased, but on the contrary deaths from uncomplicated diabetes have been practically eliminated in hospitals, where the treatment has been directed by clinicians like Joslin, Allen, Wilder, Woodyat and many others; and even in the neglected cases, with coma and gangrene, in the hands of diabetic clinicians deaths are exceedingly rare. Considering these facts one cannot escape the conclusion that an important factor in the increasing death rate from diabetes is the inadequate treatment of the disease by diet and the use of insulin.

THE DUTY OF THE GENERAL PRACTITIONER TO HIS DIABETIC PATIENT.

The treatment of diabetes is so simple that children of ten and twelve years of age learn to weigh and measure their food, calculate their own menus in grams and calories, analyze their urine and administer insulin to themselves when needed. There is no excuse, therefore, for the general practitioner,

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who must necessarily treat most cases of diabetes, not being able to direct the diabetic's diet and insulin therapy. But does the general practitioner who sees but one or two diabetics a year have the incentive to master the dietary management of the diabetes? If the physician is prepared to direct the treatment of diabetes, does he have the time, or give the time, to teach his diabetic patient, or the diabetic child's mother the principles of nutrition and the use of insulin when necessary?

Judging from the statistics quoted by Hoffman it appears that even though there are medical centers in the large cities, and many clinicians in private practice who are adequately prepared to treat diabetes, and whose death rates in diabetes must be very low, almost nil from uncomplicated diabetes, the average urban general practitioner either does not treat his diabetics properly, or there are many diabetics who have no treatment, or who do not follow the diets given them by physicians qualified to treat diabetes. The ignorant, the self indulgent and the poverty stricken diabetics usually are doomed to early death; and no doubt a considerable number of cases of diabetes belong to those classes, but there is no reason to think that there is more ignorance, perverseness and poverty in 1930 than in 1912. Certainly there is little hope of diminishing the death rates among those who cannot, or will not, be educated in the simple principles of the nutrition needed to control diabetes; but help in getting the proper food may be given to indigent diabetics by the Red Cross and other welfare relief organizations in various cities.

In the treatment of diabetes, as in every disease, only what is best for the patient should be considered; and the conscientious physician must decide for himself whether or not he is prepared to teach his trusting diabetic how to calculate food values in grams, and calories, and whether or not he understands how to adjust the insulin dosage and diet to fit the patient's individual needs. The physician treating diabetes must give adequate time to educate the patient if he hopes to get results. The best diabetic clinician is the best teacher, but "a little learning is a dangerous thing" for the diabetic and for the physician who treats the disease. As has been said before, there is no reason why any general practitioner should not become adequately prepared to treat diabetes, but if he is not, obviously it is his duty to refer his patient with diabetes to some one who has had the training and experience necessary to deal with such cases. The growing diabetic death rate is a reflection on the medical profession.

THE ADVANTAGES OF A BRIEF PERIOD OF HOSPITALIZATION IN TREATING DIABETES.

No one doubts but that the patient with tuberculosis stands the best chance to get well if he can have the educational advantages of even a short stay in a tuberculosis hospital; and so the diabetic will be more apt to learn how to manage his case if he can have hospital care under a clinician who has had a larger experience in teaching diabetics than the general practitioner who sees only an occasional case. This is particularly true of diabetic children. John of the Cleveland Clinic asserts that every diabetic child should be treated in a hospital until the diet and insulin dosage can be adjusted to the child's nu-

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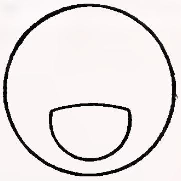

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tritional needs; and what is still more important, until the mother of the diabetic child can be taught the care of her child. As John aptly and forcefully says: "The life of the diabetic child is in its mother's hands, and she should not leave the hospital with her child until she has confidence in her ability to adjust the diet and insulin dosage to meet the varying conditions incident to the growth and development of her child."

Prior to Banting's discovery of insulin diabetes was very fatal in children; but now with insulin and diet, with an intelligent co-operative mother, the infant or adolescent diabetic may be given sufficient food to meet his needs for growth and development. Indeed, it appears that under such conditions diabetic children grow faster and develop mentally better than their brothers and sisters who do not have to be careful about their diet.

No doubt the tuberculosis hospital has played a considerable part in the reduction of the death rate of the "white plague," both by curing, or arresting the disease in the tuberculous patients; and each patient with tuberculosis who has had hospital treatment, goes home and teaches others how to prevent the disease. Likewise the death rate in diabetes may be lowered when physicians consider it their duty to send their diabetics for a stay in a hospital long enough to learn how to have diabetes and live. The diabetic who has had hospitalization goes home and he teaches the other members of his family the dangers from overeating, which no doubt is one of the most important causes of diabetes. The diabetic who knows diabetic arithmetic always takes delight in teaching other diabetics what he knows about diet and nutrition. While the diabetic should be taught that he can help other diabetics in working out their diets he should be shown that he is not prepared to treat diabetes except with the co-operation of a physician.

Of course, there are many diabetics, particularly during the present depression who have not the money to go to hospitals for even a few days, though they can get ward rates and many have not the money to pay physicians fees; and since the diabetic diet, which consists largely of vegetables, fruit, cream, and meats, is expensive, many poverty stricken diabetics must suffer, and some of them die. If the patient can procure enough money to pay for a few days in a hospital, and is not able to pay physicians fees, the clinicians on the staffs of hospitals are always glad to give their services to indigent patients; and likewise the general practitioners are ready to treat any worthy diabetic who is not able to pay for his services. It is a difficult situation for the indigent diabetic in the year 1933, and one would expect an increase in the diabetic death rate; but that may be offset by the fact that many diabetics cannot get the food to overeat, and also the incidence of diabetes may be lessened because of "chill penury."

While making investigations regarding food conditions in Germany after the signing of the Armistice in 1918 I was informed by German physicians that the incidence of, and the death rates from, diabetes was greatly reduced in Germany, since the first year of the World War when the Allied blockade became so effective that the whole German population suffered for lack of food. Perhaps one of the compensations for the distressing time through which we are passing will be a decrease in diabetes because of the enforced temperance in eating by so large a part of our population.

THE ETIOLOGY AND PREVENTION OF DIABETES.

The death rates from diabetes may be reduced most by preventing the disease; and much may be accomplished by the individual physician himself first understanding the etiological factors in diabetes; and when he has a patient, who is predisposed to the disease, he may prevent his becoming a diabetic by giving him the proper instructions regarding diet and personal hygiene.

Allen speaks of diabetes as "the vestigium of a burnt out conflagration" of the pancreas; and no doubt a previous pancreatitis is the most important etiological factor in diabetes. The foci of infection for the pancreatitis that precedes diabetes may be the tonsils, teeth, rectum, colon, prostate, female generative organs, or in any organ in the body. I have seen too many cases of diabetes with a history of a previous attack of influenza, not to believe that "flu" may be an overlooked factor in the pancreatic infection that precedes diabetes. Likewise, the acute infection of childhood, particularly scarlet fever, and also typhoid fever, may be causes of undiagnosed pancreatitis, which leaves a damaged pancreas.

Gall bladder infections are associated frequently with pancreatitis; and surgical drainage in gall bladder infections has in many cases resulted in an improved carbohydrate tolerance in diabetics. Joslin says that "gall-stones often precede diabetes and may precipitate it by direct extension of infection to the head of the pancreas." He suggests that since gall bladder infection, gall stones and diabetes are so often associated they "may have a common origin." He adds: "It is sound doctrine to advise the removal of gall stones to avert diabetes." Likewise the removal of an infected gall bladder may prevent diabetes.

Trauma may be the cause of a pancreatitis that precipitates diabetes. I reported two such cases in 1923. Recently I have had a case of hyperinsulinism which apparently followed an abdominal injury in which no doubt there was trauma of the pancreas, though the pancreatitis was not recognized at the time. If every case of abdominal injury was suspected of resulting in pancreatitis, no doubt many cases would be recognized that now are overlooked. When pancreatitis is recognized the patient should be instructed to live on a low carbohydrate diet probably for the rest of his life, because such a patient is a potential diabetic.

The theory of a previous pancreatitis should not make us underestimate over eating as a large factor in the production of diabetes. The greatest of all diabetic clinicians, Joslin, and others, have stressed obesity as a fore-runner of diabetes; and the physician may prevent diabetes in his overweight patient by pointing out to him the danger of countinuing his eating habits, by giving him a reducing diet and following up the case to see that he carries out instructions until he has become of normal weight for his age and height.

HYPERINSULINISM MAY PRECEDE DIABETES MELLITUS (HYPOINSULINISM)

The spontaneous excessive secretion of insulin (hyperinsulinism) is a definite disease entity, a symptom of which is hunger, so that the individual who has hyperinsulinism eats excessively and often between meals. The more he eats, particularly of the rapidly soluble carbohydrates, particularly cane sugar products, which stimulate insulogenesis, the greater the degree of hypoglycemia two or three hours after meals, when more food is needed to prevent a spontaneous insulin reaction; and so obesity results. A damaged pancreas from previous infection is probably the most important etiological factor in hyperinsulinism as it is in diabetes, and the overworked islet cells become exhausted and a deficiency of the secretion of insulin (hypoinsulinism) diabetes mellitus, the antithesis of hyperinsulinism follows. In other words, first a pancreatitis, followed by excessive secretion of the islet cells (hyperinsulinism), then superalimentation, which exhausts the islet cells, then diabetes.

Several of my first patients with hyperinsulinism were overweight, and had a history of glycosuria which suggested that hyperinsulinism may precede diabetes mellitus, just as hyperthyroidism sometimes is followed by hypothyroidism (maxedema); and in a symposium on diabetes, in which I discussed the etiology, at the meeting of the Virginia State Medical Association in 1923, I expressed the opinion that hyperinsulinism associated with obesity was one of the causes of diabetes. Since then I have regarded my hyperinsulinism patients as potential diabetics and have dieted them accordingly.

In the last few years on careful questioning of my diabetics, particularly those who were overweight before developing diabetes, a number have given a history of excesive hunger, and a feeling of weakness and nervousness between meals, requiring food for relief. In one of these cases the history was so clearly that of hyperinsulinism it cannot be doubted that she had spontaneous hypoglycemic reactions before becoming overweight, and before she developed diabetes. She said: "Two or three hours after meals I would get so hungry, weak and faint that I felt like I would die if I did not get something to eat, and therefore, I was eating all the time." She also said that she would almost collapse if her meals were delayed. She was underweigtht until she had those symptoms, when on account of her excessive appetite and eating between meals, she became overweight. A few months later she developed polyuria, nocturia, pruritis vulvae, weakness and loss of weight, and it was found that she had diabetes. Her blood sugar curve after a glucose tolerance test is typical of a moderately severe case of diabetes. She is an intelligent woman and learned to calculate food values, and maintains her weight and health on 135 grams carbohydrate, 60 grams protein and 150 grams of fat a day, and ten units of insulin three times a day. She had had several insulin reactions which she says affect her exactly like the hungry weak spells she had before developing diabetes.

The familiar tendency to diabetes has been observed frequently. It is interesting to note that this diabetic mother has a son who is underweight and has developed practically the same symptoms of hyperinsulinism that his mother had before she developed diabetes. He is a minister and on Sundays he would become exhausted and extremely nervous and ravenously hungry before finishing his Sunday morning sermon; but would be revived physically after eating dinner. During the week he had the same symptoms but he would eat between meals, and the weakness and nervousness were not so pronounced as on Sunday when he could not get food. His blood sugar curve after 100 grams dextrose is the typical "flat" curve of hyperinsulinism. On a low carbohydrate, moderate protein, high fat diet, with orange or tomato juice every 2 hours between meals, his symptoms have been controlled. I believe that this hyperinsulinism son of a diabetic mother is a potential diabetic.

I have had a number of cases of hyperinsulinism with sugar constanly in the urine, even though the blood sugar level is very low, i. e. 0.050 percent. It therefore, seems possible that the glycosuria in such cases is of pancreatic origin, instead of being due to a "low renal threshold." I also have had sevral cases of dysinsulinism, in which at times there was hyperglycemia with glycosuria, and at other times hypoglycemia; and in others the glucose tolerance curve shows a long fasting blood sugar, then hyperglycemia for several hours, and in four or five hours fall to a very low level. Such cases suggest a relationship of hyperinsulinism to diabetes. It therefore seems probable that the superalimentation of hyperinsulinism may be a factor in the etiology of diabetes; and that by diagnosing the disease early and placing the patient on a low carbohydrate moderate protein, high fat diet, with frequent feedings, diabetes can be prevented.

THE PREVENTION OF DIABETES A PUBLIC HEALTH PROBLEM

McCarrison is of the opinion that a diet deficient in vitamins B and C predisposes to abdominal infections; and it seems probable that a diet of white bread, white potatoes, white rice, white sugar and othe devitaminized foods, such as the majority of the American people live on very largely, may predispose to infections of the intestinal tract and secondarily to pancreatitis. The medical profession can aid in the prevention of diabetes by taking part in the campaign of education begun by McCollum to teach the American people to go back to the diet of our parents and grandparents who lived on bread made from whole wheat flour or whole grain corn meal; unpolished rice; milk and its derivatives, butter, and cheese; the green vegetables, raw fruits, and a moderate amount of meats.

Diabetes is as much of a public health problem as typhoid fever, but the death rates of the former have increased while the later is being reduced everywhere. From the viewpoint of prevention, diabetes is largely a matter of diet, or personal hygiene, while typhoid prevention is largely a question of public hygiene. Our public health authorities and the medical societies should take up the fight against diabetes. They should confer with the educators and the school boards in their communities to the end that every private and public school and college everywhere shall give instruction in personal hygiene, particularly in diet and nutrition.

The organized medical profession can also help in combatting the alarming increase in diabetes by giving the public the facts, while at the same time stressing that it can be prevented by eating more green vegetables and more raw fruits and less meats, less white bread and less sweets. Since the public has learned of the use of insulin, people generally are interested in the subject of diabetes; and now is the psycholigical time to begin the campaign for its prevention. Will the medical profession live up to its opportunities in preventing diabetes, as it has done so nobly in the fight against tuberculosis, typhoid fever and other communicable diseases?

We deeply appreciate the following letters, their reference to Percy W. Toombs issue and their very kind and encouraging words relative to the work of the editor.

Dr. W. H. Anderson,
Booneville, Miss.
Dear Dr. Anderson:

I wish you to know that I am receiving the "Mississippi Doctor" and the "Booneville Independent" with unfailing regularity and that I appreciate your great kindness and courtesy in keeping me in touch with your admirable journalistic and literary enterprises through the medium of these valuable and interesting publications.

It is not often that we see a medical man who can combine with a thorough knowledge of his profession and a wide grasp of its collective problems the talent and ability to engage in journalistic enterprises of the merit and utility of your two publications.

I was very much touched by your recent and beautiful tribute to my dear friend and one time pupil, Dr. Percy Toombs. No Eulogy was more deserved or more feelingly expressed. I read every bit of it and I thank you for the perfect way in which you interpreted my sentiments and the friendship and admiration I always felt for him, his personality and splendid career.

I note also that your "Mississippi Doctor" is not only a faithful exponent of the activities of the profession in your section of the country, but that it adds a personal touch and literary flavor to the information that it conveys. Even more, it displays a culture and a poetic taste in its editorial discussions and presentations that are rare in medical publications and that gives the "Mississippi Doctor" an esthetic quality to its utterances that are most attractive and pleasing to its readers.

For all this I congratulate you and your family who, if I may judge rightly by the names on your Editorial Staff, are your faithful associates and active collaborators in the useful task which you have so brilliantly undertaken.

With hearty appreciation and best wishes, I am
Yours very sincerely,
RUDOLPH MATAS
New Orleans, La.

Dr. W. H. Anderson,
Booneville, Mississippi.
Dear Dr. Anderson:

I have just received the February "Mississippi Doctor" and congratulate you on its excellence. I had not before heard of the death of my good friend, Dr. Percy Toombs. Your tribute to him is deserved and beautifully done. I am glad that you are publishing "Toombs Romances of Surgery."

I also appreciate your refrence to the Birmingham meeting of the Southern Medical Association. While I have no official connection with the Association it delights me very much to see it growing in usefulness under the guidance of Loranz and Dabney. Your description of the meeting is the best I have seen in any of the journals.

With best wishes, I am,
Sincerely yours,
SEALE HARRIS.
Birmingham, Ala.

EULOGY TO DR. PERCY W. TOOMBS

The writer of this article had only a passing acquaintance with Dr. P. W. Toombs, but I, like everybody who came in contact with him, could not help being fascinated with his charming personality and his brilliant intellect. His passing is indeed a great loss and real calamity to the most important branch of the profession. However, in every crisis of human experience, when the gates of the grave swing back and a great man goes in another is raised up to take his place, but the question of the hour is, Who will take the place of Percy W. Toombs?

W. C. WALKER.
Houlka, Miss.

Ole Miss Medical News

By Woodard D. Beacham

Dr. Peter W. Rowland, professor of pharmacology and materia medica at the University of Mississippi School of Medicine, was unanimously elected president of the Mid-South Post Graduate Medical Assembly at its 49th annual session held in Memphis February 14th, 15th, 16th, and 17th. His tenure of office will be the year 1934-35.

Dr. Rowland has been head of the department of pharmacology since the establishment of the Mississippi Medical School in 1903. He has been prominently identified with the various medical organizations of the South for many years and is a past president of the State Medical Association.

Formerly known as the Tri-States Medical Association, the Assembly embraced Tennessee, Mississippi, and Arkansas. In addition to those states, it now includes: Missouri, Louisiana, Illinois, Texas, Oklahoma, Alabama, and Kentucky.

William C. Gorgas was an army surgeon, apparently destined to obscurity, who freed the world from the fatal disease, yellow fever.

Robert E. Peary was a rural surveyor who finally planted the American flag upon the North Pole.

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Recent Observations In Medicine

On behalf of the officers and members of this association, I wish to welcome those physicians who have very kindly agreed to appear on our program and who have made this association and this meeting second to no other medical meeting in this country or abroad. And along with this

Through the printers' oversight the following paragraph was omitted which we greatly regret:

Dr. L. H. McDaniel, Tyronza, Ark., President's address read before the 49th session of the Mid-South Post Graduate Medical Assembly, at Memphis, Tenn., February 15th 1933.

To the members of this association I wish to express the heartfelt thanks of my friends and family for the honor of being your President. Indeed it is an honor which is not deserved, an honor that has never come to any other physician as young as your speaker, an honor that is and will be prized beyond any of which I can conceive—being a leader of physicians—that group of men who go at the call of duty, to palace and hovel alike; that group of men who hear secrets and confessions not breathed to other mortals, that group of men who are often called upon to whisper consolation to poor suffering souls on the brink of the Everlasting Silence, that group of men who are trusted with everything mortal that this life affords, that class of men who labor under a system we know as medical ethics, the ideals of which are not surpassed by any organization, religious or otherwise.

Gentlemen, I appreciate your honor and beg you to overlook my mistakes as being errors of inexperience or of youthful exuberance and enthusiasm.

For the past half century it has been the custom of the political party in power to assume credit for all good things—from winning the World War on down to the sunshine, bumper crops, and good prices, when we had them. And with the characteristic attitude of the professional politician, who "points with pride" upon every good thing he can recall. I point with pride to our Mid-South Post Graduate Medical Assembly. Because we are here brought an excellent program with a review of medical facts vividly presented, with the announcement of new facts, and the proposal of new theories which may benefit mankind and bring honor and credit to the profession. However, at this point I am not going to follow further in the footsteps of the political ballyhoo artist and view everything with alarm.

To my inexperienced mind, I can see where most satisfactory results are daily and constantly coming to our profession of organized medicine. Never in the history of medicine has the ethical and scientific physician been so greatly appreciated as a gentleman of the profession. I attribute this to the new school of medical thought which takes the patient into confidence and approaches his complaint from a scientific viewpoint, and tries to advise him thoroughly yet conservatively, and to relieve in a judicious and conscientious manner.

The theories of quackery with all their deception and false promises are falling into discard and disuse from their own unworthiness, all from a failure to approach medical situations from a scientific attitude. There is reason to rejoice that one belongs to a profession which is constantly on the alert for improvement, whether it be trying to find a method to give maximum doses of arsenic without reaction, or to perfect a major abdominal operation with a minimum amount of shock; a profession which is conservative enough not to accept every fantastic unproved medical dream, and yet progressive enough to be constantly striving and yearning for scientific and logical progress.

It is indeed gratifying to think that the public at large is beginning to be educated on medical lines enough to appreciate scientific approach at its true worth and relegate quackery and hoodooism to oblivion. I am indeed glad when I visit the offices and clinics of my brother physicians to find, instead of queer contrivances and appliances which were prevalent two or three decades ago, a happy abundance of X-rays, laboratories, and other scientific material of proven efficiency.

Nor would I have you, gentlemen, think that I am criticizing that great and good class of physicians of fifty or even twenty years ago, whose untold perseverance, unceasing efforts, staunch ethics, keen insight, sincere sympathy and devoted love of our profession have left the way easier for us, with the indispensable apparatus they helped devise, to approach disease scientifically and treat it judiciously. I respect their sowing that good seed of "proper approach and justified action" for we as doctors today are now reaping to our benefit and to their everlasting honor. But, gentlemen, they prepared the way. We reap the benefits; they carried their patients to a hospital on a few quilts in an open wagon, we have ambulance; they had to rely on signs and symptoms which were often fallible; we have the X-ray, microscope, and new chemical tests; they often could not take the laity into their confidence and diagnosis and treatment were often shrouded in mystery, consisting of some pet secret treatment or concoction. We have our methods of scientific approach, invite the patient's confidence, and demonstrate to him how we have reached the authentic diagnosis can suggest a treatment based on reason.

This is an age in which the public demands that things which would continue in general favor must produce the desired results and continue to produce them, whether it be a car, a radio, or a treatment for disease. Excessive advertising may prolong the unwarranted success of an inferior article, but it cannot hold up indefinitely—Abram's treatment, as well as other unwarranted theories, could not stand the powerful searchlight that an intensively alert public throws on everything, material and otherwise. I am indeed glad that to a large extent the day of placebos is over and that we are now searching for the cause of pathology to relieve it logically.

We are citizens as well as physicians and should and do have the general welfare at heart. Naturally our thoughts drift to the depression and amid the unrest of economic conditions we hear rumblings of discontent—rumblings and mutterings that the profession is overpaid. The general practitioner, who constitutes a majority of our physicians, and a majority of the membership of this association, certainly is not, nor has ever been, overpaid. His hardships, his privations, his sacrifices, his love of humanity have been common knowledge for decades, and no one dares even intimate that his financial returns have been excessive.

Then the question arises, "Is the specialist overpaid?" When we consider the cost of preparation, the ever-increasing high prices of new and improved apparatus and instruments, overhead expenses, etc., I am at once converted from a critic to a defender of the specialist. The fees of surgeons and specialists, have been reduced from 20 to 75 percent during the past three years and I challenge anyone to cite a similar profession where such reductions have been made. They have done this willingly—with a spirit of co-operation in their hearts. The expenses of the surgeon or specialist and the value and thoroughness of his work remains at its peak. Yet the returns requested by the specialist have been in accordance with economic conditions.

The Committee on the Cost of Medical Care has made an exhaustive study over a five-year period and some of the most able physicians of this country are members of this committee. The majority report impresses your speaker as being impractical in many features for patients as well as physicians in the cities and absolutely infeasible and utopian for patients and physicians not directly associated with a central hospital. Believing that there is as yet no need for state medicine, that such would have a tendency to destroy initiative in physicians, lower the class of service performed, and make too many citizens have an attitude that the world owes them medical service as well as a living without their working for same—or to call a spade a spade, make them medical dead beats—I strongly subscribe to the minority report.

Personally, I think that this committee who took five years of time and spent considerable money investigating should have had something to say regarding the failure of the costs of pharmaceuticals to decline anything in reason. Nor are the drug stores which often make from 100 to 1500 percent profit on prescriptions—and I want it well understood that I am not criticizing any pharmaceutical house or drug concern that is satisfied with a normal profit on his material—playing fair with an economically distressed people. We, as physicians, owe it to our patients and to ourselves to check up on this great leak in the cost of medical care just as the lay citizen should look into the cost of school books—which certainly constitutes a menace to the education of our youth in states where free school books are not provided.

What has the medical profession to offer in the future? We pledge ourselves to go on along the paths of "Scientific approach and justified action." We pledge ourselves to remain steadfast to those principles and ideals of medicine as exemplified by Polak, of Brooklyn, Toombs, of Memphis, and G. A. Warren, of Arkansas. We pledge ourselves to continue to treat every case as a separate entity—that the patient's welfare and not our gain may be our ever-guiding light. We pledge ourselves to try to be worthy of the name physician—a name of traditions and memories, of ideals and aspirations. We pledge ourselves to ever strive to place and hold the practice of medicine on the plane and pedestal it deserves.

Then, gentlemen of the profession, to epitomize the central thought of this address and to leave with you an ideal for thought and consideration, for the good of your patient and mine, and for the improvement of your community and mine I venture this: The next quarter of a century will see Preventive Medicine reach heights of service and appreciation that were undreamed of twenty-five years ago, and we physicians have a golden opportunity to share bountifully in their advance. In this day of depression when the value of a dollar looms tremendously we are unable to get far away from the economic viewpoint of any matter. We hear everywhere the clarion call to reduce the budget, cut down expenses, eliminate the superfluous, economize, economize to the quick, and we grope about uncertain what expense can be eliminated and what expense is necessary.

Gentlemen, I suggest that we, the Medical Profession, sponsor, and sponsor energetically, the education of every parent in this land in eliminating needless childhood diseases—Preventive Medicine, if you please. Every physician should advise the prospective mother that proper diet and exercise and the pre-natal, natal and post-natal care of a physician warrant a good start in life for the child. He should advise that the child be immunized at a very early age against diphtheria, typhoid fever and smallpox, that the removal of diseased tonsils and adenoids is of prime importance, that the eyes and teeth should be examined and the defects remedied, and that special attention be given the diet at all times. When we advocate these measures strenuously and persistently then we are keeping faith with both clientele and profession.

The large insurance companies which represent the only major business of our nation that has not been seriously handicapped by the depression tell us that their periodic examinations of policy holders is the best investment they make. If their results in adults is so gratifying, surely we have a most promising field in Preventive Medicine in children.

There is a distinct relatonship between diseased children and crime. Go to our penitentiaries and find them filled with boys—underweight, undernourished, stoopshouldered, of impaired vitality, possessed of many defects that should have been remedied in childhood. It is an old, old cycle. The happy schoolboy gets behind in his school work. Because of infected tonsils, or adenoids, or eye strain, he becomes discouraged, then impudent, then insolent. He stops school to walk the streets, all the time his ambition waning day by day. Soon he is a petty thief, then we find him stealing cars for a thrill and alas, crime has another convert.

I contend that if we take care of the physical bodies of our children over a period of four decades—forty years—that crime will be reduced forty percent, delinquency in our youth sixty-five percent, the burden of paupers will be reduced fifty percent, and the stature of the American youth will be increased one inch. Truly, when crime, delinquency, pauperism, and preventable disease are costing our nation billions of dollars. We, the Medical Profession, should pledge ourselves, as physicians and as citizens, to put our shoulders to the wheel of the greatest means of reducing this expense—preventive medicine.

It is my hope that we shall not rest upon our laurels, but with the enthusiasm of those tireless medical workers who have studied and given us the benefit of their toil and brain we may go on, each day getting nearer and nearer to perfection in our approach and treatment of human disease, that we may warrant and deserve a deeper appreciation from the public; that each one of us may have a great hand in the relief of human suffering and the prolongation of human life; and that the world may be left healthier and happier by our having lived in it and sympathized with it.

I thank you.

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F. B. Long—Oktibehha	H. L. Scales
E. B. Burns—Pontotoc	O. F. Carr
R. B. Cunningham—Prentiss	None Selected
A. E. Bostick—Tishomingo	J. S. Wheeler
C. E. Lehmberg—Lowndes	None Selected

Tribute To Dr. Kirk

I have been asked and I have promised to write a brief account of my contacts with Dr. R. S. Kirk, together with my impressions derived therefrom. I find that to be a very difficult undertaking—not that there is but little I might say, but because there is so much I should like to say.

My acquaintance with Dr. Kirk began on the day when I came to Amory as a boy doctor. I found that he had preceded me as a resident physician, here, by a few years. In fact, he came when the town had its birth, so to speak. I soon recognized Dr. Kirk as a modest, unassuming man—making no effort at display and setting forth no claims for superiority either as a man or physician. This trait characterized him until the day of his death. Notwithstanding, his innate modesty, his was a most attractive and endearing personality. He was endowed with a great common sense and a keen but kindly wit that was amusing and pleasing. But above all, he had a heart that was open and responsive to all human needs and frailties. It was never written in the book of destiny that he should acquire wealth or affluence as the world estimates wealth, but it was ordained that he should be rich, indeed, in the love of innumerable friends. So, in sober reality, he lived and died, perhaps, the richest man who ever honored Amory with his life and labors. Who would not prefer to live and die as did he, in those respects, than to die possessed of uncounted wealth in dollars and yet be loved and mourned by few or none. It was said by a brilliant infidel when speaking of his own brother's life and, that if every person to whom he had done a single act of kindness, should bring to his grave a single rose petal, that he would sleep beneath a mountain of flowers that would perfume the air for miles around his tomb. How truly this might be said of Dr. Kirk. I trust that his family will pardon me when I say that it is a matter of common knowledge that he left them no heritage in money—in fact, I feel sure that it will require all that remains of his life's great work to meet the expense of his last illness, thus leaving his wife who was "faithful unto death" to him and his needs, with no visible means of support. How sad this is—how cruelly sad, while if each person to whom he ministered so faithfully, almost without hope or demand for reward would give a Single Dollar toward liquidating their indebtedness to him (to say nothing of expressing their love for him), all this expense would be amply cared for. To these delinquent, so called friends, I will say shame on you if you do it not. Again, I beg for pardon from his family for these remarks.

My personal contacts with Dr. Kirk have even been most pleasant. During all these years there

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has been no incident that led to an unkind word nor so far as I am aware, to an unkind thought between us. This is as it should be and it could not have been otherwise. While our friendship was not as that of David and Jonathan or Damon and Pythias, it was true and cordial. I shall always count myself fortunate that for many years I have known that he trusted and respected me. When he was "stricken unto death," he sent for me and while he realized that I could give him no relief—and I promised him none—I know that he appreciated my presence and interest. How my heart ached to know that I was powerless to serve in a scientific way and how my heart goes out in sympathy to his loved ones. May God bless and comfort them, and may his memory dwell for years as a benediction upon the town and people for whom he lived and labored. We may not see his like again for many years.

I am proud, indeed, to subscribe myself as his friend. G. S. BRYAN.

Cancer of the Stomach

BY J. SHELTON HORSLEY, M.D.

Deaths from cancer are increasing. There are now in the United States about 120,000 deaths from cancer each year, one-fourth to one-third of them being from cancer of the stomach.

In the fight against cancer, the most powerful of the captains of the men of death is cancer of the stomach.

Gastric cancer occurs more frequently in men than in women. Clinically it may be divided into two classes: (1) the kind of cancer that gives a history of indigestion, frequently resembling the history of peptic ulcer, for several years before the cancer becomes obvious; (2) the cancer of the stomach in which gastric symptoms appear only a few months before the disease is detected. The first type represents about 25 to 30 per cent of all gastric cancers. The second type comprises about 70 to 75 per cent of the gastric cancers.

Elsewhere in the body it seems to be true that cancer does not originate directly from normal healthy tissue. In regions that we can inspect, as the mouth, tongue, skin, rectum and lower sigmoid, cancer arises on a pre-existing benign lesion such as a patch of leukoplakia. a wart, a mole, an ulcer or a polyp-like growth. It is probable that cancer in the stomach follows this same general law. In the interior of the stomach, which cannot be saisfactorily inspected, benign growths or even ulcers may exist for years, especially if in the "silent areas" of the stomach, without creating symptoms until cancerous change and rapid growth have set in. The lesser curvature of the stomach, where gastric peristalsis begins, is the important motor region and about 80 per cent of all stomach complaints are due to interference with its peristalsis. A growth or lesion of any kind in the narrow pyloric end of the stomach may also cause symptoms because of partial obstruction. Roentgenologists say that any ulcer along the greater curvature of the stomach capable of demonstration by X-ray is practically always malignant, while many of the ulcers on the lesser curvature are benign.

It is generally recognized that some gastric cancers have their origin in benign peptic ulcers. The ratio of this incidence, however, is a subject of much dispute. It is t ue, too, that there is a low-grade cancer of the stomach which ulcerates early and cannot be distinguished grossly even at operation from a benign ulcer, microscopic examination being necessary to make a diagnosis. In the opinion of Holmes and Hampton, roentgenologists of the Massachusetts General Hospital, and of many gastroenterologists, the difficulty in differentiating between early cancer and peptic ulcer is so great as to call for surgical excision, the only known means of curing gastric cancer, unless the suspected lesion responds to medical treatment within a few weeks.

Because of the proximity of the liver and pancreas to the stomach and because, also, gastric cancers are usually not very radio-sensitive, efficient radiation treatment cannot be given gastric cancer, so the only means of cure is excision by partial gastrectomy. In some rare instances a total gastrectomy is justifiable.

If a patient reaches the "tropic of cancer," say 35 years of age, and begins to complain of vague symptoms of indigestion, such as belching, nausea, water-brash, heart-burn, sometimes vomiting, pain and discomfit in the upper abdomen, whether coming on at a regular time after meals or not, he should receive a careful examination by a competent general practitioner. In the majority of cases this stomach trouble will be found to be due to something other than a gastric lesion, and can be cured by appropriate medical measures. If, however, the patient is not relieved of his complaints after faithfully followwing the advised treatment for two or three weeks, his stomach and intestines should be examined with X-rays by someone fully competent to do this.

If cancer is found, an operation should be done as soon as possible by a surgeon of experience in gastric surgery. If the lesion appears to be a peptic ulcer, Medical treatment may be instituted for a few weeks; then, if improvement as noted by X-rays and clinically is not marked, the lesion should be removed by a partial gastrectomy.

If the patient has been having stomach symptoms for many years, and reaches the age of 35 years, the same routine should be enforced.

In the early stages of disease the diagnosis is difficult, but it is in the early stages that the diagnosis is important so that proper treatment can be given. It has been shown by Dr. Margaret Warwick that in about 23 per cent of cancers of the stomach coming to necropsy the cancer is still confined to the stomach, and that many of these deaths result from perforation of the cancer and peritonitis, and not from the constitutional effects of cancer. It seems probable that, if at necropsy 23 per cent of gastric cancers are still limited to the stomach, an earlier diagnosis and a proper operation would uncover a larger percentage of cases in which the cancer was confined to the stomach and could be cured by partial gastrectomy.

It is only by adopting some plan to follow through to a definite diagnosis and treatment the earliest signs of stomach trouble that the enormous mortality from gastric cancer can be reduced.

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Petrolagar Co.	Chicago, Ill.
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New Books

Clinical Gynecology by C. Jeff Miller, Professor of Gynecology and Tulane University School of Medicine, Chief of the Department of Gynecology of Turo Infirmary, Senior Visiting Surgeon, Charity Hospital, New Orleans. This anxiously awaited book is being published by The C. V. Mosby Company, St. Louis. The price is ten dollars. The size, five hundred and sixty pages, large and well bound. His book covers malformations of the pelvis, infections and inflammations of the genital organs and urinary tract; injuries of the perineum, their prophylaxis and their treatment; malformations of the uterus, benign and malignant growths, their treatment, surgery, X-ray, radium, etc., disorders of function, dysmenorrhea and sterility, endocrine therapy, pre-operative and post-operative care. The "boys" know that when C. Jeff says it, it is that way. He says it well and to the point. He knows how to write a book that can be used. It is doubtful if any other man has ever written a book on this subject out of a more lucrative experience. He has been a tireless worker. He is a keen observer. He has the native ability. His book is a fountain source of the most dependable information that can be had on the subject. The information is in logical order and it is well said. You can practice by this book conveniently and safely. On gynecology, follow Dr. C. Jeff Miller and fear no evil. The history of all progress is largely the history of individuals who forged ahead, ones who saw and went forward. Any gynecologist, any practitioner, any general surgeon can ill afford to be without Dr. C. Jeff Miller's new book.

Scarcely have we found a non-medical book which we more like to have among the office collection for frequent use than this book by Lloyd Paul Stryker, "Courts and Doctors." And at no time, when the laity are more given to litigious proceedings than ever before, does the general practitioner need such an authentic legal adviser as this little handbook. For carefully and fully is it compiled that it might easily be substituted for your trusty counselor of the bar. To take up only one chapter in brief, the following suggestions are offered on avoiding being sued:

1. The best way to avoid a lawsuit is not to deserve one.

2. Be careful of your diagnosis.

3. Are you honestly competent to treat or operate for the malady which confronts you?

4. In all cases of surgery, consider carefully whether a surgical operation is required.

5. Make sure that all your instruments and appliances are of the most approved design and make, and are in proper working order.

6. Be careful in your choice of anaesthesias.

7. Keep careful records.

8. Do not work in the field of X-ray therapy and diatherapy unless you understand it. They are highly technical specialties.

9. Keep abreast of the times.

10. Be conservative of your prognosis.

11. Be tactful and just to your fellow practitioners.

"Courts and Doctors" is a publication of The McMillan Company. Price $2.00. New York City.

SPRING HILL, Miss.,—In the extreme western part of our school district on Henry Clanton's farm on Thursday, February 23, were born to Sherman Young and Annie Young, negroes, four babies, two boys and two girls. Three of them weighed 4 pounds each, the other 3½ pounds. They have been named Eva and Neva and Roy and Troy. All four babies are normal and healthy. The father is 28 years old, the mother 22. They have been married six years, have four children older than the quadruplets. This unusual natality has occasioned much interest and the humble negro home has had many visitors. The oldest citizens cannot remember another quadruplet case in the history of this section of Mississippi.—Ackerman Plaindealer.

"In savage tribes, where skulls are thick
And primal passions rage,
They have a system sure and quick
To cure the blight of age.
For when a native's youth has fled
And years have sapped his vim,
They simply knock him in the head
And put an end to him.

"But we in this enlightened age
Are built of sterner stuff;
And so we look with righteous rage
On deeds so harsh and rough.
For when a man grows old and gray
And weak and short of breath,
We simply take his job away
And let him starve to death."

Actual Practice in Surgical Technique

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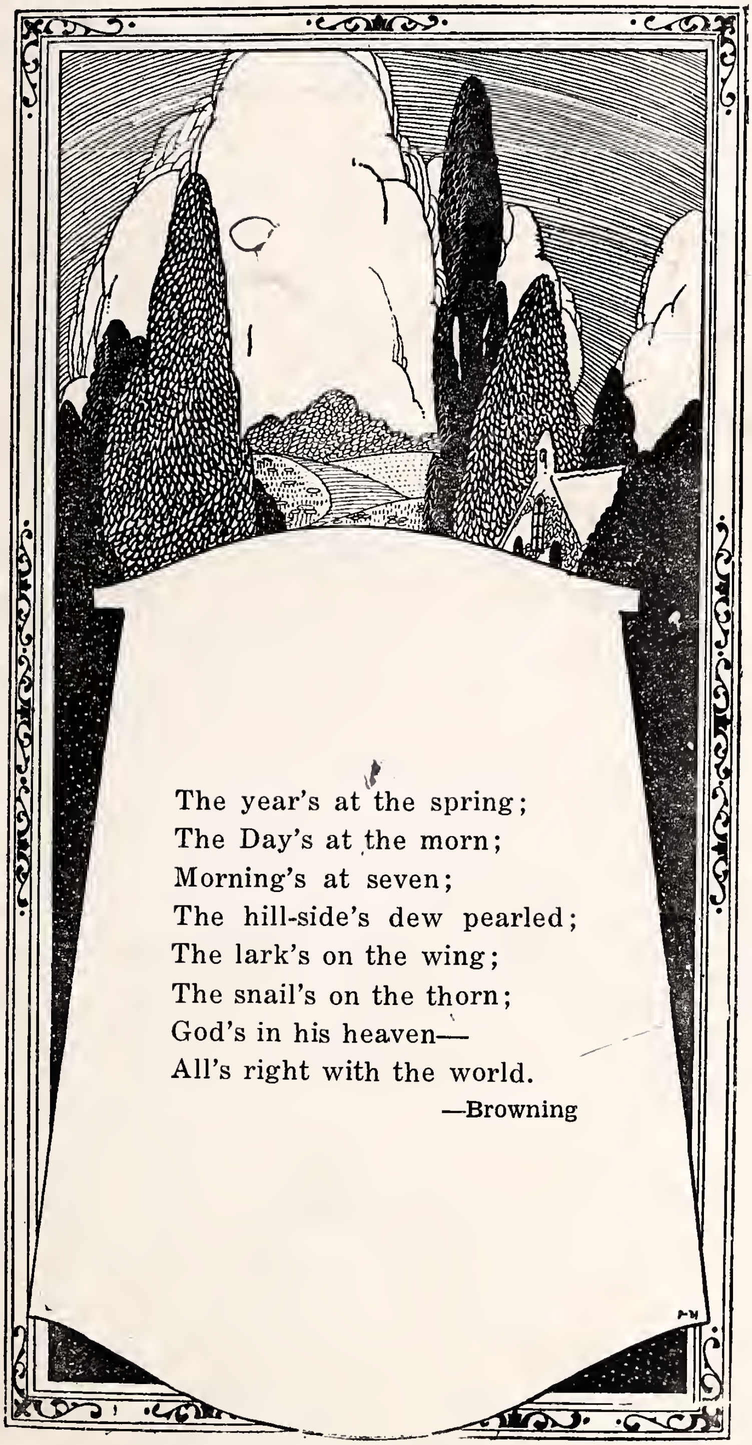

The year's at the spring;
The Day's at the morn;
Morning's at seven;
The hill-side's dew pearled;
The lark's on the wing;
The snail's on the thorn;
God's in his heaven—
All's right with the world.
—Browning

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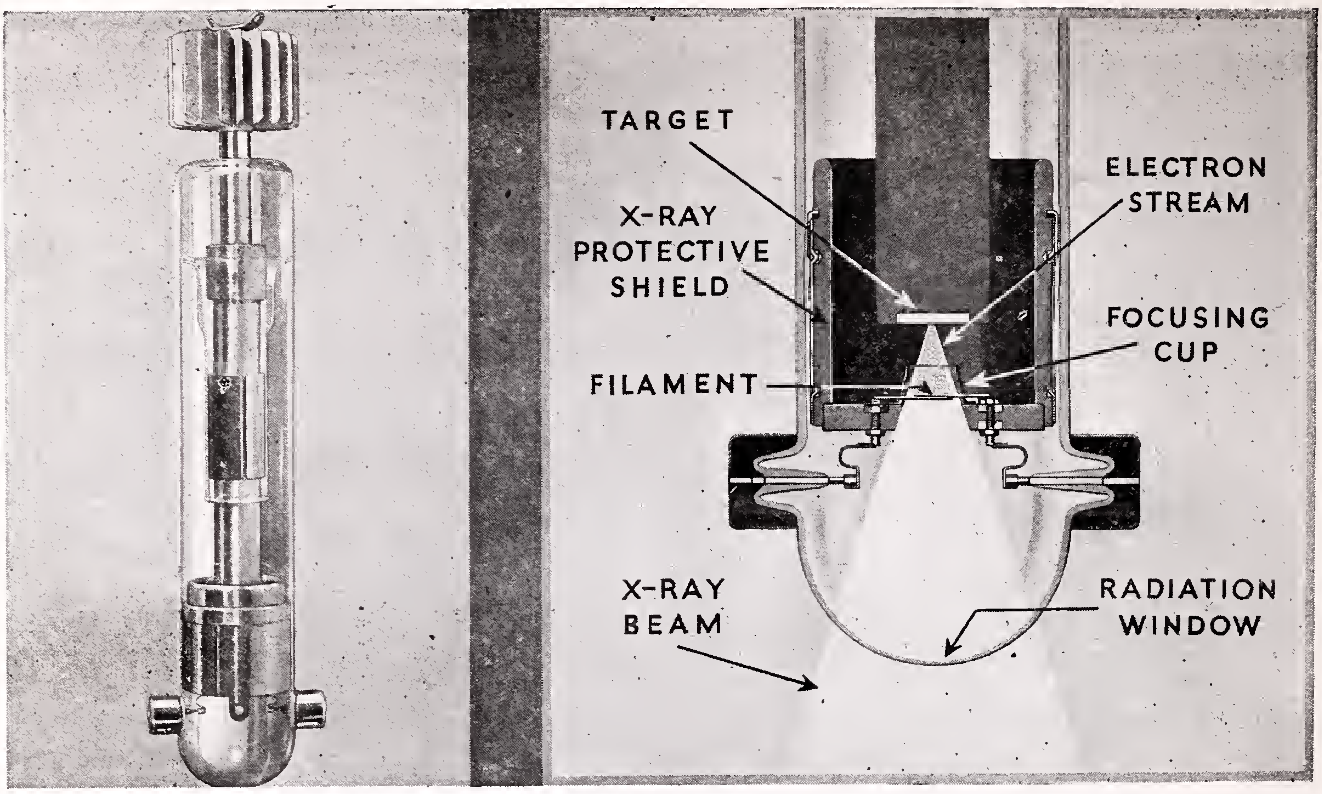

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MID-SOUTH POST GRADUATE MEDICAL ASSEMBLY

W. H. ANDERSON, M.D., Editor and Manager
MRS. W. H. ANDERSON, Assistant Editor

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We regret that we were unable to attend the first quarterly meeting of the North Mississippi Medical Society which met at New Albany on March 22. Its scientific program was fine. The "friendly city" of New Albany always makes the men glad they went. This is a splendid society. It is doing fine work. Dr. Brown of Water Valley is the new president. He is worthy and well qualified. Dr. A. H. Little of Oxford is the efficient secretary. He is always on the job for organized medicine.

No one thing is of minor importance in the practice of medicine. Let us do with our might what we find to do. Let us keep up the morale. Let us press forward. The medical profession, especially in the small town and rural community, has had it harder than any one. But it has wrought exceedingly well. It has not faltered. Let us be optimistic. Let us be brave. The opportunities for service are very great. Let us determine to do more work and do it better even if we have to do it for less.

The general practitioner, the general surgeon out on the firing line of the profession will have some patients every month who need to be sent to the base hospitals, to the real specialist. He should be alert enough to recognize these patients and he should be honest enough with his patient and with himself to send him. The practitioner in Sullivan Hollow may deserve as much credit as the specialist on Fifth Avenue. But they should join hands in co-operation for the good of the patient.

The Memphis Doctors and Mid-South territory have another treat coming about the middle of May. Look out for the program in the next issue of the journal.

President McGahey, of Calhoun City, does the noble thing by sending us a fresh crispy one spot for a year's subscription to a doctor in Birmingham. He has the vision. You can do no more for a doctor, relative or friend with one dollar than to send him the "journal." Now let about fifty or a hundred other good men do likewise. Dr. McGahey is actually doing the co-operative spirit in fine style. The doors of the subscription room are open, the price is very low, one dollar, and the best papers that can be written are in the press hopper. Get your friends on the mailing line as this man of deeds is doing.

If the community hospital is developed as it should be and as is being done in Mississippi, it will keep us away from state medicine. Our five state charity hospitals have rendered good service. It was all right to have them when we had but a half dozen or so surgeons in the state, but now when electric power has been extended to every cross roads and a good surgeon has or will follow, it is not time to hold out to an obsolete method. Let us put the old political foot balls on the shelf for the museum. When a very sick man has to go two hundred miles to a charity hospital and no way to go, it is a sad day because of the mental state of our law makers. The method outlined by the hospital committee would carry the service to the people at less cost everything considered. The man who can not see this is mentally dumb as a door knob. It will aid the development of a little medical center in every county or every two or three. It will enable the medical profession to have post graduate work at home. It will take the politics out of our state aid. Fifteen cents per capita, three hundred thousand for the entire state will do the work quite well. Our five state institutions cost a hundred thousand dollars before even one patient is treated. It is time for a "new deal." A new deal the medical profession of Mississippi is going to have.

The X-ray and laboratory are fine aids to diagnosis, but they never will take the place of the medical and surgical ear that can hear the grass grow, the sun rise, the moon set, and the stars come out; an eye that can see the sap rise, the sun ray, the thoughts of man emenate, the mind of woman change, see the chemistry of digestion and the blending of the secretions of the ductless glands. And in addition the doctor needs to have the intuition of a rural mother, the medical knowledge of Pasteur, Matas, and Moynihan, the wisdom of Solomon, and the sympathy and the justice of the Healer of Nazareth.

Our hearts go out to Dr. Charlie B. Mitchell of Starkville in the loss of his wife. She was a true wife, a noble mother, and a constant inspiration to her family and to all with whom she came in contact. She was cultured and refined and broadly educated. Dr. C. B. Mitchell is one of the ablest and noblest in our society. Our society extends its hand of sympathy to him and the four fine sons.

You will read with much interest our University of Tennessee Department edited by I. S. Coe. We are glad to have this. It makes a nice addition to our journal. If you have some good news let him have it to send along. You will note from the young men listed in this news item that some of our biggest citizens and ablest educators believe in this university. Memphis is one of our greatest Southern cities and it has a fine medical atmosphere.

Be sure to read the resolution on the Ole Miss Medical Department passed by the North East Mississippi 13 County Medical Society at its last meeting. The two year medical course at Ole Miss is second to none in this country. It has stood the test. It has not faltered. It is still putting out this high grade work. Its graduates stand at the top in their junior and senior years in other schools. They make good records as internes. They distinguish themselves on state board examinations. They are resourceful in practice. A large per cent of them return to Mississippi. They are inspired with a vision. They catch the spirit. They are taught to work and to win by merit. They learn to do better with less means. They are resourceful in practice. This school is picking up the young men of limited means who are endowed with the professionad mind, the medical soul and the missionary heart and are given a chance to embark on the voyage of this great profession. Marble buildings with tile floors do not make a medical school. A teacher is the biggest asset of a medical school. We have too many doctors now, but not of the type this school turns out. We have a shortage of doctors in the rural communities and small towns. It may be because the medical schools have taught their students too much in terms of costly hospitals, operating rooms, internes and nurses, taught them away from the small town, from the general practice. It is time to teach the medical student to do more efficient work with less means. You can't turn a costly crank and put out a real doctor. Ole Miss medical school should be restored to its regular standing and should be given a glad hand and a God bless you for what it has done and is doing. It is no time to raise the requirement now. When it lags in its efficiency it will be time enough. Let us keep this school to teach others how to do better on less means. The destruction of this school is unjust, unfair and "uneconomical." It is time for our state medical profession to stiffen its back. It is time for our Governor and our board of trustees to show their interest and their loyalty. It is time for the naional medical council to be fair and to be sensible.

The first quarterly meeting of the North East Mississippi 13 County Medical Society met at Macon on March the 21st. This was our first meeting at Macon we believe. The Secretary asked that the banquet be left off and it was. But even so we met with a mighty clever bunch of doctors. They held out a cordial hand and was most generous in heart. They met and looked after the guests in fine style in every way. We are obligated to Dr. Hill for a full feed at a mighty nice cafe. The John Allen Hotel is one of the nicest we have seen in that size town. The town generally is up "to snuff." You could not keep from feeling the cordial atmosphere. The theatre furnished one of the nicest meeting places we have had. Our new president, Dr. McGahey presided in fine style, efficiently with ease and dignity. The program was unusually good. Dr. Scott of Birmingham, our visiting essayist, was up to the last word on "Infantile Paralysis." Young doctor Rayburn presented a classical paper on the attitude and concept of the profession. This was his first paper before our society. We welcome him and congratulate him. Dr. Lilly presented one of the ablest discourses we have ever had from a local man on his subject. Dr. McRae was not with us muchly to our regret. We took a liking to Macon and we believe we will be invited back. We shall be waiting to go.

FRACTURES

(An Editorial by Dr. Isidore Cohn)

The old conception that fractures are simple broken bones is rapidly disappearing.

It must not be overlooked that an injury of sufficient violence to produce a fracture must be great enough to produce soft tissue damage. The associated injury may and often does involve nerves, muscles and blood vessels. Failure to consider this fact results in many unnecessary and preventable disabilities.

One who undertakes to treat a fracture should carefully examine his patient and be prepared to treat associated injuries. The examination of the in-

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jured part should be done systematically. The history is of the greatest value. It is not only necessary to obtain how, but when the accident occurred. It is essential to know what functions have been lost. Loss of function when interpreted anatomically is of inestimable value.

Inspection enables one to note change in the axis of the limb, the altered attitude of the part, whether the patient voluntarily protects and supports the injured part, and many equally valuable points of information.

Palpation, which should be light, adds the next valuable link in the chain of evidence, localized pain.

Crepitus should not be sought for. Any movement which causes pain is harmful.

The X-ray should be utilized for confirmatory evidence and not as a substitute for a careful examination. Many fractures are overlooked by placing too great a dependence on X-ray examinations. This is particularly true in children. Until the epiphyses have ossified and union has taken place between the diaphysis and the epiphysis fracture through the epiphyseal line and fracture within the cartilaginous epiphysis will not be shown by X-ray examination.

It is important that the term epiphyseal separation should be discarded in favor of epiphyseal fracture. The term, separation, implies a loose contact, whereas in reality the condition that exists is a cartilaginous fusion. Unless the definition of a fracture as it is now accepted is discarded, then the term epiphyseal separation should be relegated to the limbo of oblivion.

In children the clinical examination plus a knowledge of the normal relationship of the epiphysis to its respective diaphysis is of more value than an effort to see a fracture line which cannot be demonstrated.

Careful examination and proper interpretation will enable one to avoid for the patient the sad results which follow when an unrecognized fracture has been passed over as a sprain. This term is too often a cloak for ignorance or indifference.

The diagnosis of a fracture once made calls for immediate treatment. There are fads and fancies in the management of fractures as in every thing else. Often times one finds that too much is done. Poor judgement is exercised in an effort to follow the dictates of authority. The simplest measures are often the best.

That method which has for its object the restoration of function through the application of anatomic knowledge along well established physical principles is best.

Operative measures are used all too often.

When operative surgery is applied due attention should be paid to the avoidance of unnecessary damage to muscle and nerves.

The splendid results which some of the masters of technic have reported have given many doctors an unwarranted impression of the ease with which such results can be duplicated. Many who are neither qualified by training nor environment pursue the operative plan of treatment to the ultimate harm of their patients. The bad end results thus obtained do not find their way into the literature.

Adequate diagnosis and early application of conservative methods of reduction and immobilization give satisfactory results in the vast majority of cases.

The end results are dependent largely on after care, provided adequate reduction has been accomplished. Pain following reduction and immobilization is indicative of incomplete reduction or a tight bandage. Neither of these can be relieved by drugs. The pernicious habit of ordering sedatives should be stopped. The part should be inspected. Loosening of the constriction will relieve many a pain and prevent that terrible complication known as Volkmann's ischemia.

Prolonged immobilization should be avoided as atrophy of bone, as well as the soft tissue, results.

The nutrition to the part should be kept up by early application of heat and active exercise.

The promiscuous use of various forms of physiotherapy cannot take the place of heat, well applied massage and graded active exercise.

Early diagnosis is essential. Immediate reduction under an anesthetic and well supervised after care will produce satisfactory results in the majority of cases.

The Revolution In The Treatment Of Pulmonary Tuberculosis*

BY DUANE M. CARR, M.D.

Rest is the specific treatment of all forms of tuberculosis. The involved lungs must be placed at rest while the patient's resistance is built up with the usual measures of good hygiene. Rest of both lungs is maintained to a degree by rest in bed as the physiological demands upon them are diminished. However, rest may be concentrated where it is most needed, in predominantly unilateral disease, with collapse therapy.

By means of collapse therapy the volume of a lung may be decreased to any desired extent. Healing takes place when fibrous scar tissue contracts about infected foci and when cavities are similarly obliterated. This contractile force is normally opposed in all directions by the relatively rigid bony cage and the strong muscle of the diaphragm since the intrapleural negative pressure forces the lung to fill the entire hemithorax. If spontaneous healing is to take place, the thoracic wall or the mediastinum must be pulled in or the diaphragm elevated. In a few minutes or a few days collapse therapy can accomplish this part of the process of healing which would otherwise require months or years.

The presence of a cavity feeding tubercle bacilli into the sputum is a constant menace to a patient, no matter how gratifying his clinical condition, because of the danger of a bronchogenic spread of the disease and because of the toxic absorption which so often leads to damage to other organs. All cavities must be closed before a patient can be said to be safely on the road to recovery.

Collapse therapy can be applied with benefit to at least 65% of all cases of pulmonary tuberculosis. Several sanatoria report its use in as high as 67% to 77% of all admitted cases. Cases discharged from one of them as "apparently arrested" have quadrupled since the beginning of collapse therapy five years ago. At the same time the death rate has been more than cut in half. With earlier application of collapse therapy and fewer patients reaching the "hopeless" stage, these figures will almost certainly improve. Not only has the prognosis been completely changed for a large group of patients, but the time required for arrest of the disease has been materially reduced. Earlier use of minor collapse measures will reduce the need for major measures which are costly both in time and money.

Phrenic nerve interruption (temporary or permanent) will reduce the volume of the hemithorax 400-800 cc. when the pleural space is free of adhesions. It will also stop 28,800 daily movments of the diaphragm which are normally transmitted throughout the entire lung. This combination affords rest and permits a great deal of scar tissue contraction without opposing resistance.

The unfavorable progress of a large number of incipient cases (20% at the Trudeau Sanatorium) un-

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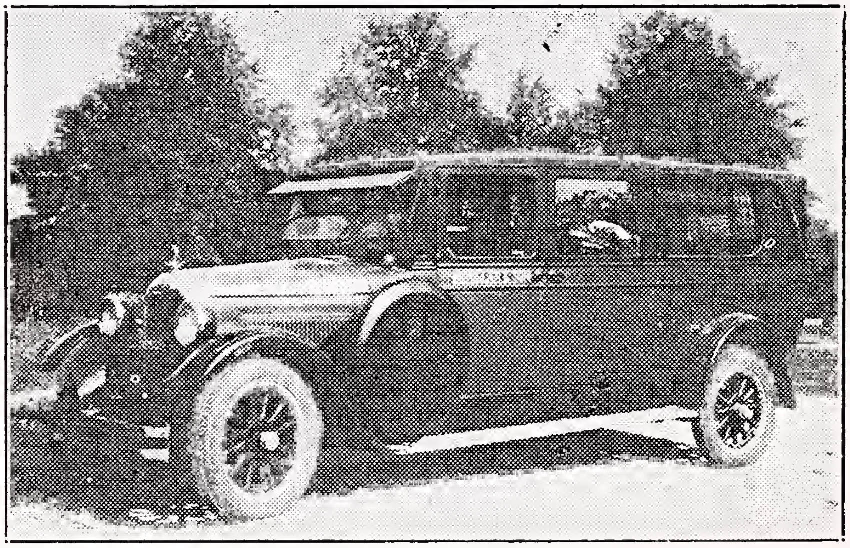

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der the best of sanatorium care justifies a rapidly extending use of this operation in early unilateral disease. Marked clinical improvement and closure of cavities often follows operation in chronic, moderately or far advanced cases in which pneumothorax or thoracoplasty are not contraindicated but in which phrenic interruption might be expected to accomplish the desired result. Dr. E. J. O'Brien reports closure of 90% of small multiple cavities, 59% of thin-walled round or oval cavities, and 7% of thick-walled irregular cavities following phrenic interruption . The effect of this procedure in checking hemoptysis places it in the category of emergency operations.

Phrenic nerve interruption should be used as a substitute for or a supplement to a pneumothorax which fails because of adhesions to give a satisfactory collapse. As a preliminary step to thoracoplasty, it often results in sufficient improvement in the patient's general condition so that a previously contraindicated operation may safely be performed. Lesions in the better lung may be so improved following temporary phrenic nerve paralvsis that a thoracoplasty or other operation may be performed on the worse side. The contraction of an apparently healed lung is maintained and premanent protecting rest afforded by a phrenicectomy (permanent paralysis) performed before resumption of a normal active life. The operation is often used at the time of abandoming a successful pneumothorax so as to decrease the size of the hemithorax in which the scarred, healed lung must expand. In acute, highly febrile, progressive, predominantly caseous types of tuberculosis, phrenic nerve interruption is not often successful in checking the disease, but the few cases in which the temperature returns to normal, the sputum diminishes in amount, and signs of severe toxemia disappear a few days after the operation, make it a procedure worth trying.

A temporary phrenic nerve interruption (crushing of the nerve and resection of any accessories) is usually best in an adolescent or young adult whose lesion is of brief duration and in whom appearance of the disease in the opposite side is feared. The main trunk can readily be found at a second operation and resected if permanent paralysis is desirable when the diaphragm resumes its function.

The phrenic nerve is exposed through a small incision a finger's breadth above the clavicle with the sterno-cleido-mastoid muscle retracted medially. The phrenic nerve on the anterior scalene muscle is identified, the accessories arising from the brachial plexus are resected, after which the main trunk is either crushed (temporary) or resected for 2-3 cm. (permanent). This is a modification of the Goetze radical phrenicectomy. Exairesis, as described by Felix (1) (2), with its danger of tearing the subclavian vein or mediastinal pleura, is reserved for those cases in which no accessory phrenic nerve can be found.

Pneumothorax is almost ideal when the pleural space is free of adhesions and when extensive collapse and rest are desired, Rapid diminution of toxic symptoms and closure of all but the most rigid cavities may be expected following a well established pneumothorax. With the closure of cavities the sputum becomes negative to the most exacting tests

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and the danger of spread of infection into hitherto uninfected lung tissue greatly diminished. Clinical improvement is usually rapid.

The folly has been demonstrated of maintaining for month after month a partial pneumothorax which is ineffective because of adhesions. The adhesions must be divided with cautery if possible or the pneumothorax supplemented with phrenic nerve interruption or thoracoplasty.

Bilateral pneumothorax is not uncommon and may safely be applied when both lungs require collapse therapy. Not infrequently we have paralyzed the diaphragm on the side of a lesser lesion when the opposite lung was partly collapsed with pneumothorax with no sign of air hunger, and later increased the pneumothorax without causing distress.

Complications following artificial pneumothorax are few and, when handled with understanding, rarely fatal.

Intrapleural pneumolysis under thoracoscopic control (Jacobaeus) occasionally yields spectacular results. A lung which stubbornly refuses to collapse because of band or cord adhesions holding out the part of the lung most needing compression tends to fall away to a perfect collapse following cauterization of the offending adhesions. It is however, an operation requiring of the surgeon extensive training and experience because of the difficulties of orientation and of decision which adhesions may and which may not be safely cauterized without causing hemorrhage and a possibly fatal empyema.

Open intrapleural pneumolysis under direct vision and with the adhesions transilluminated is a safer procedure when there is any question of their being too short or containing vessels or "tents" of lung tissue. We frequently explore the pleural cavity with the thoracoscope to determine the advisability of cauterization by either method since it is a well known fact that the X-ray frequently fails to reveal the actual condition.

Severe complications in trained hands are rare. When fluid forms, as it frequently does, is must be aspirated and the pneumothorax continued lest adhesions form which are more extensive than before.

If a phrenic nerve operation and a pneumothorax have been undertaken and have failed to bring about healing of the lesions, the suitability of the patient for a scaleniectomy, an intercostal neurectomy, or an extrapleural pneumolysis should be considered before determining upon a thoracoplasty.

Scaleniectomy, the resection of portions of the three scalene muscles, reduces the rise and fall of the upper three ribs and, when combined with phrenicectomy, is used enthusiastically in some clinics to rest apical lesions and aid in the closure of thin-walled cavities lying high in the apex. The effect of scaleniectomy is difficult to ovaluate, since it is usually combined with phrenicectomy, but in our experience with about 15 patients, one case of hemoptysis was checked with scaleniectomy after phrenicectomy had previously been performed and his condition sufficiently improved to permit final closure of his cavity with a partial thoracoplasty.

Multiple intercostal neurectomy is the partial resection of the intercostal nerves near the rib angles. The paralysis may be made temporary by merely crushing the nerves. This operation practically abolishes movement of the thoracic wall. Although there is little collapse, the general unilateral rest distinctly helps healing of a diffuse, caseating lesion throughout one lung. We have used it successfully as an independent procedure and as a preparation for thoracoplasty. Its usefulness is limited.

Extrapleural pneumolysis is the freeing of the two adhered layers of pleura and underlying lung from the thoracic wall. Various materials have been used to maintain this separation of the adhered pleurae from the overlying ribs, but we favor the use of paraffin. Relaxation of the lung is obtained by gently stripping the parietal pleura from the ribs and intercostal bundles in the cleavage plane of the endothoracic fascia and filling the space between the parietal pleura and thoracic wall with a special paraffin mixture. Its best use is for local compression in the treatment of localized lesions containing a cavity high in the apex.

Extrapleural thoracoplasty must be considered not as a last resort, but in any predominantly unilateral, moderately or far advanced case in which pneumothorax is impossible or ineffective and which fails to make genuinely satisfactory progress with the lesser procedures that have just been described. When the patient's general condition warrants operation and the opposite lung is free of active tuberculosis, operation should not be delayed. So long as a cavity exists and there are tubercle bacilli in the sputum, there is danger of bronchogenic spread of the infection. When cavities are obliterated and toxic absorption diminished, tuberculous infection of the larynx, intestines, ect. often disappears and there frequently results a marked improvement in any lesions which may exist in the contralateral lung.

Any desired degree of collapse and rest may be obtained with a thoracoplasty. It must be performed in stages. It is advantageous to resect not fewer than the upper seven ribs so that the scapula may fall inward and act as a compressing pad. Only occasionally for very limited apical lesions should fewer than seven ribs be removed. A complete postero-lateral thoracoplasty consists of resection of the upper eleven ribs from the tips of the transverse processes laterally in varying lengths, depending upon the location and size of the diseased area to be compressed. If the cavities to be closed are large, the upper anterior rib stumps and cartilages must be removed to the sternum. Failure to close cavities with a thoracoplasty is usually due to failure to remove sufficient lengths of rib.

All forms of collapse therapy must be supplemented with the usual hygienic measures of a sanatorium regime. Any major surgery should be followed by six months or preferably a year in a sanatorium, during the latter part of which time gradually increasing exercise may be advantageously prescribed

The major operations in thoracic surgery now carry a lower mortality rate than do operations in major abdominal surgery. This has been brought about by greater understanding in the selection of operations for patients, the division of extensive procedures into stages, improved anesthesia, and the precautions taken to prevent stasis of infected secretions in the bronchi which cause postoperative pneumonia.

All the graded steps of collapse therapy are designed to produce rest concentrated where it is most needed and to assist the natural contraction of a healing lung. The earlier in the course of the disease that the proper collapse treatment is applied, the fewer advanced cases will there be requiring extensive operations and, even more importantly, will there be fewer patients in whom the disease has progressed so far that it is beyond human aid.

SUMMARY

1. Collapse therapy is an intensive application of the rest principle.
2. It reduces a lung's volume so that fibrous tissue may contract unhindered about lesions and cavities.
3. It can be applied with benefit to the majority of all cases of pulmonary tuberculosis.
4. It changes a hopeless to a hopeful prognosis in many patients and shortens their convalescence, an important economic factor.
5. Phrenic nerve interruption (temporary or permanent) is used alone when a moderate degree of rest and collapse is sufficient, and is used with other collapse measures to supplement their action.
6. Artificial pneumothorax is ideal for more extensive collapse when the pleural space is free of adhesions, but must be supplemented with other measures when ineffective.
7. Intrapleural pneumolysis (closed or open) is capable of converting certain incomplete pneumothoraces into satisfactory ones.
8. Varying degrees of pulmonary relaxation and rest will be obtained for special indications with scaleniectomy, multiple intercostal neurectomy, and various forms of extrapleural pneumolysis.
9. Thoracoplasty will produce any desired degree of collapse and rest but requires rigid selection of patients, expert performance of the operation, and meticulous attention to preoperative and postoperative details.
10. The mortality rate of major thoracic surgical operations is far less than that of the disease itself treated by the best sanatorium methods.

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The Empyema Problem*

BY DUANE CARR, M.D.

In the last analysis the diganosis of a suspected empyema is made with the aspirating needle. When pus is present, it is usually most surely found in the middle of the dullest area, wherever this may be. When there is doubt as to whether the trouble is a posterior empyema or a basal pneumonia, it is well to remember that the lower thoracic spine is dull or flat to percussion in empyema and resonant in pneumonia.

Aspiration of fluid from the pleural cavity that is found by smear or culture to contain pyogenic organisms calls for a definite course of active treatment. If the history indicates that the empyema is younger than two weeks (three weeks in thin streptococcus fluid) or if the aspirated fluid is thinner than skimmed milk, it is probable that firm pleural adhesions have not yet formed.

Open drainage under such conditions and upon a patient whose vital capacity is probably low by virtue of a recent pneumonia or other grave pulmonary disease may cause collapse of both lungs and suffocation of the patient. The in-rushing and out-rushing of air through the drainage tube, in the presence of a mobile mediastinum, may so disturb the heart and great vessels that cardio-circulatory failure will contribute toward an early death through anoxemia. These matters have been ably discussed by Graham and Bell (1).

Open drainage during the early days of an acute empyema may not kill the patient if his reserve muscular strength is sufficient to overcome the dangers that have just been referred to. If he survives, and if the pleural adhesions that the empyema had begun to form between the lungs and the parietal pleura were not yet sufficiently strong to withstand rupture by the inrushing air, the entire lung will collapse toward its hilum and a total empyema of one pleural cavity, with a grave ultimate prognosis, will result in place of the restricted one that existed before drainage was performed.

Until open drainage becomes safe by virtue of the formation of pleural adhesions strong enough to keep the lung from collapsing and the mediastinum from "fluttering" from side to side with respiration, either needle aspirations or closed drainage must be performed to relieve the patient of the presence of the large amount of toxic material contained within the empyemic fluid and to relieve his heart and the respiratory surface of his lungs from pressure that can eventually stop the function of both the heart and lungs.

Air-tight drainage is ideal for the period before open drainage becomes safe but the usual method of introducing a catheter between the ribs does not result in true airtightness for more than three or four days and the subsequent sucking of air around the tube has the same (or through the trapping of air within the empyemic cavity a worse) effect upon the patient as a too early open drainage. The air tight system that we use (Alexander [2]) is effective but it requires a sure technic for safety. The far more complicated method of Deryl Hart (3) is said also to be effectively air-tight. For occasional use, I feel that repeated aspirations are preferable, because safe and effective, to air-tight drainage.

When aspirating, care should be taken that no air is sucked into the pleural cavity. The amount that should be aspirated depends on the amount of fluid and upon the patient's reaction. If dyspnoeia, pain, marked increase in the pulse rate, or cough should occur, aspiration must be promptly stopped and, if the symptoms are severe, 50, 100 cc, or more of air should be introduced into the pleural cavity through the needle so as to allow the lung and mediastinum to return somewhat toward its pre-aspiration position. As a general rule, not more than 500 cc. should be removed at one sitting. When huge amounts of fluid are present, it may be well to aspirate once or twice a day for one or two days and then daily until most of the fluid has been removed and the lung expanded. Thereafter, aspiration every two, three or four days should be enough. I do not favor the introduction of air to replace in part the aspirated fluid as a therapeutic method for the reason that when this fails to cure the empyema, a total empyema of the hemithorax remains which has a very bad ultimate prognosis. Nor do I favor attempting to cure the empyema by indefinitely repeated aspirations during one, two, or three months. This will cure some patients, but during the treatment the patient is being damaged by varying degrees of dangerous toxic absorption; those who are not cured are left with a chronic empyema.

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*From the Department of Surgery, University of Michigan, Ann Arbor, Michigan.

Open tube drainage should succeed the temporary period of aspiration as soon as the criteria for probably firm adhesions are manifest. Probably nothing in the treatment of empyema is more important than the way in which open drainage is performed and maintained. A piece of a rib and the underlying thickened pleura (which should be routinely examined microscopically for tuberculosis) should be resected and a drainage tube, not smaller than one's forefinger and having a large lumen, introduced so that its inner end protrudes not much more or less than 2 cm. within the empyemic cavity. Along side of it a small catheter or a long, fine tube of any sort should be introduced well into the empyemic cavity and the two tubes anchored firmly to the skin with a safety pin and adhesive straps—not merely with adhesive straps. The smaller tube is an important addition for the introduction of antiseptic solution irrigations every two, four, or six hours. If these are made directly into the drainage tube, the empyema is distended and a fatal air embolus may result and the new fibrous tissue that is pulling the lung out to the thoracic wall so as to obliterate the empyema will be broken up. If there is no broncho-pleural fistula, the patient should lie on his unoperated side with his hips raised on pillows, just before the solution is introduced and for fifteen minutes thereafter so as to give the antiseptic a chance to kill the organisms on the walls of the cavity.

It is of supreme importance that the tubes be placed at the absolute bottom of the cavity, not even one inch above the bottom. Failure to observe this rule is responsible for many a chronic empyema needlessly resulting from a sub-acute one. The simplest way of determining the bottom of the empyema before the incision is made for drainage is to aspirate with a syringe and needle in each intercostal space from below upward until pus is found. The posterior axillary line, and not the mid or anterior axillary line, is the best position for drainage of the great majority of empyemas. Tubes placed here do not keep the patient from lying on his back. If placed farther forward, the posterior part of the cavity will not drain when the patient assumes the natural position of lying on his back.

The huge majority of empyemas will become completely cured by expansion of the lung and obliteration of the cavity if the tubes are placed as suggested and maintained in position for as many weeks or months as may be necessary for complete obliteration of the empyema. Obliteration may be tested for by temporarily removing the tubes and gently sounding with a curved uterine sound or, if a remaining sinus is inaccessible to the sound it may be filled with lipiodol and a roentgenogram taken. A useful method of recording progress toward obliteration is to measure, at intervals, the amount of antiseptic fluid that the cavity will hold, the patient being placed on his unoperated side and with his hips raised so that the drainage tube is at the highest point of the empyema cavity.

The proceduce that has been outlined will allow the development of but few chronic empyemas. Chronicity is occasionally caused by the presence of a broncho-pleural fistula, tuberculous infection of the pleura, a lost rubber tube in the pleural cavity, osteomyelitis of a rib, or by other rarer causes.

When a patient presents himself with an empyema already in the chronic stage, it will usually be found that drainage is ineffective because there is only a small sinus without a tube. Even if a tube is in place, it will probably be found to be too narrow for adequate drainage, to be unaccompanied by a second tube for antiseptic irrigations, and not to have been placed at the very bottom of the empyemic cavity. It is, therefore, likely that a new operation is necessary to place a proper pair of tubes in the proper position. At this time a section of the parietal pleural scar should be examined microscopically to determine whether or not tubercles are present.

Even though this re-drained empyema may be many months old, the chances are hugely in favor of adequate drainage resulting in great decrease and perhaps total closure of the cavity. Drainage and irrigations should be maintained for as many months as measurements of the cavity show that it is progressively decreasing. As with tube drainage of any empyema, the patient must be carefully instructed when he leaves the hospital for home treatment that the tubes must be kept in exactly the position in which they then are and that if they should become displaced or come out that they must be replaced in the exact position within 24 hours so as to prevent the rapid contracture of the sinus which often prevents reintroduction of tubes of adequate size. It is true that removal of the tubes as soon as the discharge from the cavity becomes scanty and the organisms few results in some cases in closure of the draining sinus and spontaneous re-expansion of the lung, but in many patients this procedure will result after some weeks or months in reaccumulation of the pus and recurrence of the empyema, which then demands a new drainage operation.

If measurements show that the cavity has ceased contracting, one of two things must be done to close the cavity. Either the lung must be made to come out to meet the thoracic wall or the wall must be made to move in to come in direct contact with the collapsed lung. The first object may be attained in some cases by widely opening the empyemic cavity and stripping the scar from the surface of the lung—the so-called Delorme-Fowler decortication operation. In many patients a line of cleavage for the stripping cannot be found and even if the decortication can be completed the lung may refuse to expand to meet the thoracic wall.

In order to make it possible for the thoracic wall to fall in, the ribs overlying the empyema and, for a technical reason, those portions of the ribs that border upon the limits of the cavity must be removed. This operation is the Estlander extrapleural thoracoplasty. Almost always it results in a considerable decrease in the size of the cavity but if the parietal pleural scar is old, dense, and thick, this may hold out the thoracic wall in much the same way as the ribs had. If this proves to be the case and, after waiting for several months for the cavity to decrease in size as much as it will, the thick parietal pleural scar together with the intercostal bundles and costal periosteum is removed completely from over the residual cavity. This is called a Schede thoracoplasty and properly includes resection of both the ribs and th soft part just mentioned. The rigid flat scapula may roof over a high empyemic cavity after a Schede thoracoplasty and prevent it from becoming obliterated. So as to obviate this, it is well to plan the original thoracoplasty incision in the postero-lateral muscles of the thorax and loin so that a large apron of muscle will be left attached to the scapula, which muscle may be loosened from the skin and rolled up under the scapula and anchored to the top of the cavity so as to fill it. This is a very effective way of closing a broncho-pleural fistula.

Both the Estlander and the Schede thoracoplasty are shocking operations for patients who have been weakened by many months or even years of chronic suppuration and it is therefore necessary that great care be taken with the preoperative preparation of the patient and that he be transfused if quite anemic. It is especially important that the operation be divided into three, four, five or as many more stages as are necessary to make the operation safe for the particular patient. By observing the many precautions that are necessary and by taking advantage of the modern technical improvements in thoracoplasty, these operations are not only safe but result in a very high percentage of cures.

TUBERCULOUS EMPYEMA

A tuberculous empyema that is not secondarily infected with pyogenic organisms must never be drained in any other way than with a needle. Many patients' lives can be saved by their doctors' refusing to put tubes into such empyemas, no matter how febrile the patient may be nor how thick and ugly the aspirated pus.

The simplest rule for the tentative diagnosis of a pure tuberculous empyema (in contradistinction to a mixed tuberculous and pyogenic empyema) is that it must be assumed to be a pure tuberculous one if smear or culture of the aspirated pus fails to reveal pyogenic organisms. As tubercle bacilli are difficult to demonstrate by smear, culture or even by guinea pig inoculation in some cases, failure to find them must not be used as evidence that the empyema is not tuberculous. Also, an empyema in the presence of known pulmonary tuberculosis should be assumed

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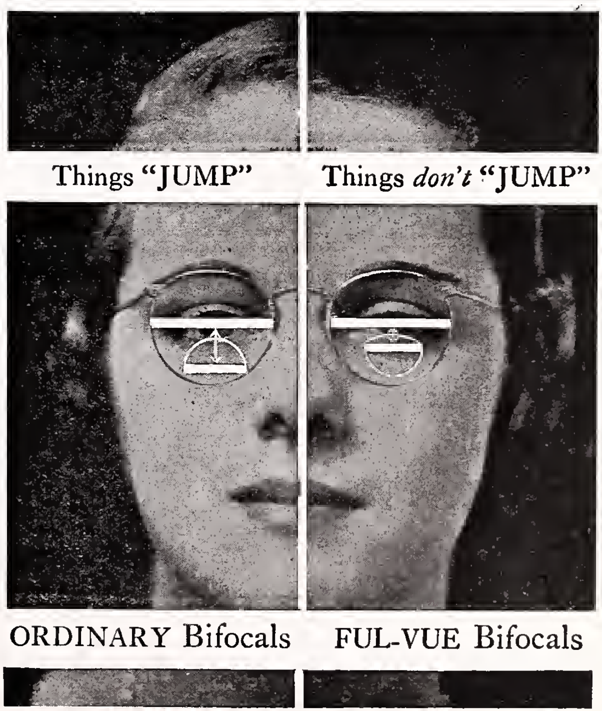

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to be tuberculous.

A serous tuberculous effusion should be left alone for several months if it is not causing harmful pressure symptoms. If at the end of that time it has not showed signs of spontaneous absorption, it should be kept dry by aspiration and, if tuberculous disease within the lung makes continuing collapse of the lung desirable, the aspirated fluid should be replaced by filtered air. If the lung does not require continuing collapse, an effort should be made to get it to expand.

If this procedure does not result in absorption but in a gradual thickening of the pus, it may be wise to perform an extensive staged extrapleural thoracoplasty in order to obliterate the empyema before it becomes infected with pyogenic organisms, perhaps as a result of rupture of the pus into the lung or externally through the thoracic wall.

If at any time a tuberculous empyema is found to be infected with pyogenic organisms, it should be treated in approximately the same way as a non-tuberculous empyema would be treated. In this group, however, it is well to make a brief attempt to sterilize the cavity with repeated aspirations and lavages with antiseptics if the infection is mild. If tube drainage should become indicated, as it usually does, it is best first to use air-tight drainage (even though the empyema may not be of recent onset) which may be converted into the more adequate open drainage if the former proves to be inadequate to keep the patient free of toxic symptoms.

A mixed tuberculous empyema with open drainage is considerably less likely to become obliterated by expansion of the lung than is a non-tuberculous empyema. For this reason, an Estlander thoracoplasty usually becomes necessary and should be performed as soon as the patient becomes a suitable operative risk following open drainage. It is frequently necessary to obliterate the residual cavity with a small Schede thoracoplasty, perhaps with the addition of a pedicled muscular graft.

The treatment that has been outlined will completely cure large numbers of tuberculous empyemas and the disease is no longer the hopeless one that it was considered to be only a relatively few years ago when surgery was not used until the patient's condition was practically hopeless.

SUMMARY

1. An acute empyema should not be drained with a tube until thickening of the aspirated pus indicates that the pleural adhesions have become sufficiently firm to resist rupture when they are exposed to atmospheric air pressure through an open drainage tube.

2. Aspirations, repeated according to the demands, should be carried out from the time of first diagnosis, to relieve the patients of the symptoms of toxic absorption and pressure upon the lungs and heart.

3. When open drainage becomes presumably safe, a section of rib should be removed in the posterior axillary line at the lowest point at which pus can be aspirated, which should be at the very bottom of the empyemic cavity.

4. Into this opening should be anchored a finger-sized drainage tube with a large internal diameter,

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not merely a catheter. Beside it should be placed a small catheter or other small tube in order to carry the antiseptic irrigating solution.

5. These tubes should be retained in place until careful soundings or lipiodol roentgenograms show that the cavity has become completely obliterated by expansion of the lung until it meets and adheres to the thoracic wall, or until the physician is satisfied that this usual outcome will not take place.

6. If prolonged simple drainage with antiseptic irrigations cannot close the cavity, the lung must be brought out to the thoracic wall by a pulmonary decortication operation or the thoracic wall must be dropped in upon the lung by either an Estlander or a Schede thoracoplasty, or both.

7. A pure tuberculous empyema should never be drained with a tuble.

8. An empyema must be assumed to be tuberculous if pyogenic organisms cannot be found in the aspirated fluid by smear or culture.

9. If a pure tuberculous empyema will not dry up after repeated aspirations, an extrapleural thoracoplasty should be considered.

10. If a tuberculous empyema becomes infected with pyogenic organisms a brief attempt may be made to sterilize it by aspirations and antiseptic irrigations, but if these fail, as they usually will, closed drainage should be performed and this should be succeeded by open drainage if the former proves to be inadequate.

11. The majority of openly drained mixed infected tuberculous empyemas eventually require an Estlander or Schede thoracoplasty, or both.

12. The scheme of management that has been outlined requires minute attention to detail which is rewarded by excellent results in the overwhelming majority of cases.

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Prenatal Program as a Routine Procedure of a County Health Department*

BY NORRIS C. KNIGHT, B.S.M.D.

I

In this paper it is my purpose to show that a Prenatal Program as a Routine Procedure of a County Health Department is practical, well worth-while, valuable to obstetrician, midwife, health worker, and the community as a whole, that it should be one of the major activities of any health department, and if prenatal patients are not receiving prenatal care from the practicing physicians the responsibility devolves upon the health unit; and also that prenatal care is a major problem confronting the health workers and medical profession of every county and city in the United States today. In the following paragraphs the term Infant Care is frequently referred to in connection with prenatal care. This is because these two fields, in my opinion, overlap and go hand in hand. In doing prenatal care we are also doing infant care because it is my idea that infant care should at least begin at the time the mother becomes pregnant.

The primary function of a health department, the primary reason for its establishment and inclusion in the body politic was and still is the control of communicable diseases. In defining problems confronting the health department the communicable disease problem rightly holds first place. I think it will be admitted without argument, however, that any county health department should have a balanced program; and as a corollary to this proposition it may be stated that the smaller the unit the more necessary the balance. In considering the essential activities which go to make up this program the subject assigned to me for discussion most certainly has a prominent place. Any county health unit that does not carry on a Prenatal Program as one of its major activities is carrying on an unbalanced and a defective program. By this I do not mean to say that a county health unit should make prenatal care a continuous and persistent feature, although to obtain results in prenatal care it is necessary to put forth continuous and untiring efforts always. It is usually unwise to confine concentration and effort to a single phase of health work for too long a period. The people become tired of being educated too persistently on one subject. They like an occasional change of topic.

It is my belief that the prenatal program has been neglected by some health departments. I think that in some departments the prenatal care has been left up to the nursing staff, and has been done more or less by home visiting methods. Recent investigations have conclusively revealed that where prenatal care is left up to the nursing division, and where it has been done by home visiting methods, it has proven very inadequate and ineffective and does not bring about the desired results. In other words, unless a medical examination, blood pressure, urinalysis, etc. is done by a physician the prenatal program does not achieve the desired results. Please understand that this is no reflection whatever on the public health nurse. She cannot be expected to do the work of a physician.

Prenatal care is a universal problem. It makes its appeal in every community and in almost every home. The methods to be employed have been evolved as an outgrowth of successful experience and it has been demonstrated that they can be employed successfully by county health units. Results of thorough work will be reflected in the mortality statistics as promptly as in most other activities, or perhaps more promptly.

Unfortunately all the people cannot be thoroughly educated overnight with regard to any public health procedure. Moreover, even after they are convinced of the wisdom of changing customs and habits, much time is consumed before the improved practices become general and the results are registered in the mortality tables. Notwithstanding these difficulties the prenatal program offers many advantages as a feature for a local health unit around which the other activities can be built. This is universally recognized now as being among our most important problems and will be supported by the public as readily and for as long periods as will any of the routine procedures of a health department, but even in featuring this subject the best interests of public health will not be served unless, at the same time, other activities generally expected of the health department receive due attention. The featuring of any important health problem by a county health unit has been demonstrated to be practicable and advantageous. This, of course, presupposes that effective, clear cut procedures will be employed and tangible results be forthcoming with reasonable promptness. An impressive result thus obtained will create public confidence which, in turn, will enable the health workers to stress other important problems in an orderly manner, and will aid in securing adequate appropriations for the department.

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*Read before State Public Health Conference, Jackson, Miss., Dec. 1932.

II

The question which, I am sure, is uppermost in the mind of many health officers as well as myself, is whether prenatal care should be left to the field of clinical medicine or to the field of preventive medicine and public health. There is some diversity of opinion on this question. I think that the sincere health worker should not be interested so much in who does the work as in the result obtained. Personally, as a health worker, I do not propose to undertake any activity that is generally recognized as belonging to the field of clinical medicine. The practice of medicine should be entirely the province of the practicing physician, and he should consider it a part of his duties to practice preventive medicine, as well as curative medicine, among his patients. In cooperating with the practicing physician and in attending to general public health duties which cannot be expected of practitioners of medicine, the health officer will be fully occupied. If the medical profession will proceed to provide proper prenatal and infant care, which will undoubtedly reduce our excessively high maternal and infant death rate, then the health officer should co-operate as far as practicable. If reasonable progress is being made by physicians along this line, or is in prospect, the health officer should devote attention to other important duties, of which there are more than enough to take up all of his time. If the medical profession—in spite of cooperation offered by the health department—cannot or will not do the work necessary to save the lives and health of women in the childbearing stage, then the problem becomes a charge upon the health department, and the health department is justified in following the next logical step, which is obvious.

It seems to me unnecessary and unwise for the health worker and the physician to engage in controversy. There is more than enough work for all. A fair and reasonable basis for getting the work done should be established, common ground should be found, and co-operation and good will should prevail. Any other course will prove very costly to all parties concerned, as the cause of public health will suffer. The introduction of a controversial question in this discussion is not in order. I mention it here because my subject is devoted to prenatal care as a permanent and major activity in the program of a county health department.

III

Health departments everywhere attempt to put over an active educational program. As the public becomes educated to better health methods in general they are demanding better health supervision for the expectant mothers of our country. The public is confronting the medical profession with the question "Why don't you do something about it?" We should not wait until the public demands this of us; we should present it to them.

Let us take a look at our present maternal and infant mortality rates, which reveal to us another outstanding demand for prenatal care. A satisfactory method for translating health activities promptly into tangible evidence of health conservation has not yet been developed. The mortality records are reasonably complete so they afford about the only universal basis for measuring the results. At the same time this means of measurement is far from satisfactory because it will not reflect promptly and definitely many activities that we know to be valuable.

The maternal death rate of the United States is appalling. We must face the facts that the United States lags behind the civilized world in the prevention of maternal deaths. According to Doctor Fred L. Adair, Chairman of the Committee on Prenatal and Maternal Care, of the White House Conference, in his bulletin issued in August, 1931 "Three-fourths of the maternal deaths in the United States are due to preventable causes." The birth registration area was established in 1915. At that time the maternal mortality rate for the United States was 6.7 per 1,000 live births. Today it is just the same. Since the advent of the health department we have witnessed astounding decreases in the incidence of typhoid, diphtheria, smallpox, and other communicable diseases. But have we seen our maternal mortality rate lowered? Most emphatically not. Today it is practically the same as it was fifteen years ago. There have been fluctuations in our maternal mortality rate during the last few years, but it has been upward, not down. This may be because prenatal care, as practiced by our health departments, is new and has not yet had time to show itself in the mortality tables.

Prenatal care entered the field of Public Health only a few years ago. Before 1921 no state health department in the United States included prenatal care in its program. At that time the Maternity and Infancy Act was passed by Congress, and the state health departments began to recognize that it really was an important problem. Mississippi, I believe, was one of the first states to take advantage of this Act.

Infant mortality rates, on the other hand, have seemingly responded to the efforts put forth to lower them. In 1910 about twenty per cent of the total deaths in the United States occurred among infants. The decline of this percentage to approximately eleven per cent in 1931 represents actual achievement.

Each year about 2,500,000 babies are born in the United States. The cost of about 17,000 of these babies must be reckoned in terms of their mother's lives. That is, each year, about 17,000 women die in our country giving birth to babies. This is the annual casualty record in the army of American mothers which has been in a state of mobilization continuously during the one hundred and fifty odd years of our country's existence. The women of this army are continually risking their lives and have kept on giving birth to the Nation itself. In the last and most disastrous war the world has ever known 50,604 men lost their lives. Besides these 50,604 battle deaths should be placed the less romantic but no less heroic deaths of women from causes related to childbirth in the same number of years. Not merely for a short period, but every day in every year death takes its toll from the ranks of American motherhood.

We should all stop and consider the question "What is the cause of our high maternal mortality rate, and what part of it is preventable?" I am sure we are all familiar with the causes of maternal deaths and I feel safe in saying that two-thirds of these deaths could be prevented by proper prenatal care. In other words, at least 10,000 of the 17,000 women who lose their lives annually in the United States from causes related to childbirth, could be saved if provided with proper prenatal care.

Let us consider, for a moment, our stillbirth problem, which is a sadly neglected problem in the subject under discussion. The Bureau of the Census has been collecting information concerning the incidence of stillbirths only since 1922. Data concerning infants who have no postnatal life are most inaccurate because of the varying rules and regulations existing in different states in regard to reporting such cases, and because of incomplete reports made by the doctor, midwife, or parents. However, the data available indicate that during the last eight years there has been no material reduction in our stillbirth rate. This data also indicates that the three greatest causes of stillbirths are complications of labor, syphilis, and the toxemias of pregnancy—the greater percentage of which are preventable by prenatal care. Of these three causes the one which probably concerns us most here in Mississippi is that of syphilis, because of our large negro population. Statistics reveal the fact that at least 24% of the patients attending prenatal clinics of the Sunflower County Health Department have syphilis. Most of these patients are apparently healthy and well, and without the routine Wassermann the disease would not be discovered. If no treatment is given probably one-half of these pregnancies terminate in abortions, miscarriages, or stillbirths, and probably one-half of those born alive die within their first year of life. The remainder join the ranks of congenital syphilitics in the community—defective, miserable, children who constitute the greatest tragedy of syphilis. If suitable anti-luetic, treatment is given to the syphilitic woman early in pregnancy, and continued until delivery, we know that in the great majority of cases

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we can assure the mother of a live baby free from syphilis. The problem of securing treatment for these patients is an unsolved problem facing the medical profession at this time. Certainly some means of providing this treatment could and should be worked out. Surely no health problem offers such an opportunity and such a challenge to public health workers and the medical profession today. The means of preventing congenital syphilis are at hand; we now face the problem of application of medical methods tested and proved.

Before leaving the stillbirth problem I wish to emphasize the first and most essential step in preventing stillbirths and congenital syphilis; namely, a routine examination for syphilis, including Wassermann, on every prenatal patient.

IV

The results obtained from a prenatal program are directly indicative of the quality of work done by health personnel laboring in the field. Some of the results that can be expected from a thorough prenatal program carried on by a health department are as follows:

A. A lowering of the maternal and infant mortality rate in that county.

B. A prompt lowering of the stillbirth rate.

C. An increase in the number of normal labors and normal pregnancies.

D. Removal of much anxiety, dread, discomfort, and suffering on the part of the patient both prior to confinement and during delivery.

E. The early and much more satisfactory and effective treatment that can be given to the complications of pregnancy such as toxemia, syphilis, heart and kidney disease, etc.

F. A healthier, happier, and better educated county of mothers and children.

G. The winning of the confidence and favor of the people of the county which is necessary to put any health department on a firm basis and which in turn will enable health workers to stress other important phases of health work.

I wish to take up just a few minutes of your time to outline briefly the program of prenatal care as carried on by the Sunflower County Health Department, and the results obtained therefrom, which serves to illustrate that a Prenatal Program as a Routine Procedure of a County Health Department is practical, valuable, and well worth-while.

As you probably all know, the Rockefeller Foundation Training Station at Indianola was operated in connection with the Sunflower County Health Department from July 1, 1927 to July 1, 1932, at which time it ceased operating. In 1928 Doctor Janney, Director of the Training Station and County Health Officer, realizing the need and demand for prenatal care in the county appeared before each midwife club in the county and explained to them the advantage of a prenatal clinic and informed them that such a clinic was to be started at Indianola and that they (the midwives) were to explain it to all prenatal patients and encourage them to attend the clinic. Doctor Janney also explained it to the medical profession in the county and ever since the clinics were started

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many practicing physicians have referred their cases to the clinics for prenatal care, realizing the advantages to them. The midwives worked hard, explaining to their patients what attending the clinics would mean to them and encouraging them to attend, and much of the credit for the success of the clinics rightly belongs to the midwives. The nurses of the health department also started home visiting to prenatal and postpartum patients, explaining to them the purpose of the clinics and encouraging them to attend.

As time passed prenatal patients applied to the Indianola clinic for care in increasing numbers and a clinic was inaugurated at Ruleville, twenty-six miles away, soon thereafter. At these two places, clinics were first held monthly and as the number of patients applying for care increased the clinics were held at two weeks intervals at each place.

About the last of 1929 clinics were inaugurated at Moorhead and Blaine, being held in a midwife's home at each of these places. At Indianola and Ruleville the clinics were held in the offices of the health department. The clinics at Moorhead and Blaine were held monthly, and patients applying for prenatal care have continued to increase in number ever since the clinics were started. The same results occurred in the clinics at Midway and Rome which were started in 1930 and were held in a school house at each place, and held monthly. In 1931 new clinics were started at Bethlehem and Inverness, being held in a church monthly, and with the same results as the other clinics.

The clinics have proven to be very popular and the number of patients applying for prenatal care have constantly increased, as evidenced by the following figures:

Number prenatal clinics held, 1929, 35; 1930, 46; 1931, 90; 1932 to Dec. 1, 98.

Number prenatal patients under supervision, 1929, 312; 1930, 404; 1931, 658; 1932 to Dec. 1, 766.

Number prenatal examinations, 1929, 538; 1930, 778; 1931, 1272; 1932 to Dec. 1, 1567.

Number postpartum examinations, 1929, 63; 1930, 113; 1931, 200; 1932 to Dec. 1, 335.

About 95% of these patients are colored, although the clinics are open to every prenatal patient in the county. The population of the county is 72% colored and 27% white, the total being 68,000.

The personnel of the department consisted of two doctors, four nurses, one secretary, one sanitary inspector. The trainees, of course, aided in the clinics during their course of training. On July 1, 1932, when the Training Station ceased operations the personnel was reduced to one doctor, two nurses, one secretary, and one sanitary inspector. The only ones working in the clinics, of course, are the nurses and doctor.

At that time the clinics at Midway and Bethlehem were abolished due to the fact that we could not give the time to them and maintain our other activities. These patients, however, live within easy reach of the Ruleville and Indianola clinics as is shown on the map here which also shows the location of all the clinics.

As the map reveals, we are now holding clinics in six different places in the county, and the clinics are so located as to be within reach of every one within a radius of eight miles of each place. This arrangement covers the county. Clinics are held once every three weeks in each place, averaging eight clinics per month. The day of the week is always the same for each place. For instance, the clinic at Moorhead is always on Thursday, Ruleville on Tuesday, etc., and are always planned eight to ten months in advance. The clinics are held at each place on the day of the nurses home visiting in that district, so that when the clinic is over the personnel disburses and works the remainder of the day in that district; thus preventing loss of time and travel in going to another district where she might be due on that day. All the equipment for each clinic, except tables, is carried with us from the office. As to the time given to each clinic, we are usually there and ready to start work by nine A. M., patients have all previously been given cards informing them of the date they are to appear at the clinic and they are always informed to come in the morning. As I said previously, we start work usually about nine A. M. and work until we get through, depending on the number of patients we have. If we get through by one P. M. we disburse the clinic for the day and go about other duties in that district. If at one P. M. we see that we are going to have to work until two o'clock or later we take time out for lunch. During the winter months we usually get through by twelve or one o'clock. During spring, summer, and fall we usually have to work until three or four P. M. Thus you see that during the winter we devote about two and one-half days per week to prenatal work, and during other seasons about two days per week.

Postpartum patients are advised to come for examination six weeks after delivery, at which times the patient and baby are both examined and advised as to their condition. Infant and preschool examinations and immunizations are also done at the prenatal clinics.

As to the routine of the clinic, as each patient enters she is given a number which is attached to her personal history record, beginning with number one. As her number is called the nurse in the admitting room takes the patient's history at a table secured from the midwife's home. The patient then obtains a sample of fresh urine in a bottle which the nurse gives her at the time of admission. The urinalysis is then made by the doctor at a table prepared for that purpose. The patient then goes to the Wassermann table where a specimen of blood is taken for Wasserman either by the doctor or the nurse, most of the time by the nurse. A routine Wassermann is taken on every patient upon her first visit to the clinic, and as often thereafter as indicated. The patient's blood pressure is then taken by the doctor at a table set up for that purpose. The patient then goes to the scales where she is weighed. She is then completely undressed and put on the examining table where the doctor gives her a complete physical examination, including heart, lungs, pelvic measurements, etc., assisted by the nurse. If anything abnormal is found the doctor instructs the patient accordingly, and if a physician's care is needed the patient is referred to her doctor and a letter is sent to him explaining the findings. If everything is normal the nurse gives the patient the routine advice, gives her a card upon which is written the patient's name and the date for the patient to return. Every prenatal patient is advised to use a doctor in preference to a midwife, both for prenatal care and at the time of confinement. Each patient has an individual record card upon which is recorded everything that is done at each examination.

During the first five months of pregnancy every patient is advised to attend the clinic at least once every six weeks. She is given a thorough physical examination at least once every nine weeks during the first five months of her pregnancy and oftener if indicated. From the sixth to the ninth month of pregnancy the patient is advised to attend the clinic every three weeks and is given a thorough examination each time.

The midwives of each district are required to attend the clinics of that district each time. This helps the clinic, and also educates the midwife as she is present at the time the patients are examined and hears the advice given. The midwife club meets on the day of the clinic, at the place where the clinic is held, and is held immediately after the clinic is over.

The nursing staff attempts to make home visits to all prospective prenatal patients, postpartum patients, and prenatal patients under supervision of our prenatal clinics as their conditions warrant; but in a country whose population is approximately 68,000 you can easily see that the home visiting service to these patients is necessarily shamefully inadequate. Two nurses cannot possible do the home visiting that should be done and keep in touch with other phases of the work.

One of our major problems in our prenatal program is the incidence of syphilis, approximately 24% of our prenatal patients being affected. Every patient that has a positive Wassermann is referred to her doctor for treatment with a letter from the health department telling him of our findings. The percentage of the positives receiving treatment averages about thirty-two per cent; roughly, only one-third of these patients who have syphilis receive treatment. It is believed that present economic conditions are responsible for the fact that such few patients receive treatment, as they are all very much interested in their condition. I believe that at least ninety per cent of them would receive treatment if it were available.

The enclosed graphs serve to illustrate the results quite well. Since the prenatal program was inaugurated in 1928 the maternal death rate of Sunflower county has steadily decreased, whereas it was very fluctuating before.

The results of the clinics as shown in the maternal mortality tables reveal the fact that for 1931 the maternal mortality rate for patients attending the clinics was 1.2 as compared with 5.6 for the entire county. The graph on infant mortality shows a very marked drop from 1930 to 1931. The stillbirth rate of Sunflower county has shown a constant decline beginning with ninety-nine stillbirths in 1928 to sixty stillbirths in 1931.

The attendance of patients at the clinics has been given in previous figures.

The medical profession in Sunflower county as a whole approves our prenatal program and co-operates with us in every way possible, and we do our best to reciprocate. We are very proud to have this co-operation and approval and we regard it most highly. The prenatal program, as well as all the other activities of the Sunflower County Health Department, are carried on realizing that there can be no permanent success of efforts to promote the health of the people and to prevent disease without the active sympathy and support of the medical profession. I sincerely believe that any health department which does not fully appreciate the relationships which should be maintained with the practicing physicians is doomed to failure, regardless of the degree of efficiency attained, or the worthiness of the cause presented.

Of the 1,336 births in Sunflower county in 1931, six hundred and fifty-eight prenatal patients, approximately one-half, attended the prenatal clinics operated by the health dpartmnt. No doubt 1932 will see this proportion at two-thirds or three-fourths.

CONCLUSIONS

The Prenatal Program should be one of the major activities of any health department.

The Prenatal Program as a routine procedure of a health department is practical and valuable in many and various ways.

The Prenatal Program offers many advantages as a feature for a local health department around which the other activities can be built, and is well adapted to working out a co-operative program between the health department and the physicians of the county.

If the medical profession is not providing proper prenatal care in a county, or if such provision is not in prospect, then the responsibility becomes a direct charge upon the health department.

To be effective and to achieve the desired results the prenatal program must receive the active participation of the health officer.

A definite demand from various sources is being made for more adequate and more effective health supervision of expectant mothers.

A county health department can carry a thorough and effective prenatal program as a routine procedure and still maintain a balanced program in relation to the various other activities.

To achieve permanent success in the prenatal program, or any other activity of a county health department, it is most essential that the health workers secure and maintain the active co-operation of the medical profession.

◆

Patience and strength are what we need; an earnest use of what we have now; and all the time an earnest discontent until we come to what we ought to be.

Advances in the Treatment of Pulmonary Tuberculosis in the Last Twenty-Five Years

BY ROSWELL ELMORE FLACK, M.D.
Memphis, Tenn.

In selecting this subject, I am fully aware of the fact that nothing startling has been discovered, but there have been some notable advances made in the treatment of tuberculosis in the last twenty-five years. In order to bring these advances to you forcefully one should compare the end results obtained today with thise of twenty-five years ago. There are physicians present who were practicing medicine twenty-five years ago and are able to recall the attitude of the profession when a diagnosis of tuberculosis was made. Invariably a grave prognosis was made and a very small per cent recovered. Today a much more favorable prognosis is made and a much larger per cent regain their health. Twenty-five years ago the tuberculosis specialist was an object of pity and received commiseration from his professional brethren. This attitude changed and he now receives the same respect accorded to specialists in the various branches of medicine and surgery.

What has brought about this change? To answer this question, progress in treating tuberculosis will have to be detailed.

The advances may be divided into five subdivisions:

1. Improvement in Diagnostic Methods.
2. Air and Rest Cure.
3. Specific Therapy.
4. Collapse Therapy.
5. Chemotherapy.

IMPROVEMENT IN DIAGNOSTIC METHODS

I shall not attempt to give a complete accouont of each improvement but only mention with brief comment the important advances in diagnosis.

The accumulated experience of the study of a large number of tuberculosis patients in sanatoria has given us much knowledge. We noted the various symptoms of early tuberculosis that are many times brought out clearly in the history. These gave us working clues. Besides improvement in history taking we have improved in our physical examination. The advent of the X-ray has meant much in diagnosis and also in the control of the progress of the patient.

The laboratory technique in the examination of the sputum, blood and spinal fluid for tubercle bacilli has improved much and has been an aid in clearing up many obscure diagnoses. The pathology of tuberculosis is much better known today than formerly. We now know the pathology of the early tubercle, its evolution and its ultimate destiny. This knowledge helps us much in diagnosis and also in prognosis and treatment. We have also gained experience in making the tuberculin test and often derive useful information in helping clear up a diagnosis. Complement fixation is an aid in some cases, but not as much as the tuberculin test.

AIR AND REST CURE

We have not discovered any new principles in regard to the air and rest cure, as they were outlined by Brehmer, Dettwiller and others. However, we have learned to carry out the principles announced by these pioneers in more detail and apply them in a larger number of patients. This point is well illustrated in the handling of tuberculosis patients by Sir William Osler. In his wards, he permitted those with fever of 100.5 to be up a great part of the time and even those with fever of 101/102 to sit up for an hour or so once or twice daily. He saw that others were getting better results than he by keeping febrile patients at complete rest and later followed their practice. When active afebrile patients were kept in bed by specialists he looked upon this procedure with doubt. Only a few years before his death he accepted this procedure as beneficial. This example will no doubt parallel many such cases and illustrates how the principles of the classical air and rest cure are being applied more intelligently and in an increasing number of patients yearly.

There may be discoveries that will aid us greatly in treating tuberculosis and I believe there will be but the bed rock of all therapy will remain the air and the rest cure. Nothing will supplant it for the pathology of tuberculosis is such that time and rest are essential to effect healing.

SPECIFIC THERAPY

In 1882, Robert Koch announced the discovery of the tubercle bacillus and definitely established the etiological agent of tuberculosis. This was an epochal discovery and it was thought tuberculosis would soon be controlled. With the isolation of the causative organism of tuberculosis, it was believed that a potent virus, as in smallpox, would soon be prepared. The scientific world was waiting for such an announcement and was prepared for it. Koch announced the preparation of his lymph, or old tuberculin, in 1887, and claimed great therapeutic value for it. Time proved that his claims were unfounded and that tuberculin has been released upon premature experience and knowledge. Much harm resulted as the dose was many times too large and the type of case was wholly unsuitable for its administration.

Since the days of the early tuberculin era we have gained much useful knowledge in the use of specific therapy. We have been able to winnow the chaff of extravagant claims from the golden grains of truth. We now know how to select suitable cases for specific therapy and to reject the unsuitable. We have also learned that the cases that promise the most benefit to be derived from specific therapy are those with limited tuberculosis and who are afebrile. Specific therapy used judiciously in such cases is an adjunct; no one who has had adequate experience will deny it.

Specific therapy has not written "finis" after all the good that has been accomplished by its use, as the field of immunology is broad and only a beginning has been made. The work of Calmette of Paris gives much promise. He has been able to successfully immunize calves with his bile culture of tubercle bacillus. This is a great step forward and this work suggests that on perfection of his method, it may be successful in protecting children from tuberculosis.

COLLAPSE THERAPY

Under this heading we mean to include artificial pneumothorax, thoracoplasty and unilateral phrenicotomy.

In 1819, James Carson the English physiologist, proposed the theory of artificial pneumothorax, but its practical demonstration awaited upon Forlanini who published his first results in 1894. This was a great discovery and it is gradually growing in favor as its application and principles are better understood. In some cases its results are nothing less than spectacular. In cases that would soon die from exhaustion, the successful application of pneumothorax really brings them back from the brink of the grave and restores them to usual health and usefulness. In cases of persistent bleeding with free pleural space, the hemorrhage is promptly checked and the patient's fears as well as his family's of impending death are relieved. As knowledge increases, its application is being extended. Even partial bilateral compression has been successfully obtained with good results. And the last word of its usefulness has not been written.

When artificial pneumothorax is not successful, we may resort to thoracoplasty. This procedure is gaining popularity as its application is better understood. We are realizing more and more that the so-called hopeless case of tuberculosis is no longer hopeless when studied in the light of recent advances made in therapy. Such procedures need the close co-operation between the surgeon and the internist. In this country, Lilienthal, Alexander and others are doing thoracoplastic operations with increasingly good results.

Before resorting to thoracoplasty unilateral phrenicotomy may be tried. This procedure is also helpful in some cases of partial artificial pneumothorax. Its application is indicated when the lesion is basal or in the lower lobe. On section paralysis occurs in the corresponding half of the diaphragm and collapse of the lower third of the lung follows.

CHEMOTHERAPY

It has been a dream of the chemotherapist for centuries to discover some substance when introduced into the body that would cure disease. After Erlich's discovery of salvarsan a new impetus was given to investigators in this field to renew their efforts.

About two years ago Prof. Moellgard announced his discovery of sanocrysin, or auro-thio-sulphate, a gold salt, and also his animal experiments and therapeutic results in tuberculosis. His report appeared to conform to all of Erlich's tenets, as he claimed that the tubercle bacillus was killed in vivo. After the administration of sanocrysin, both in the experiment animal and in the tuberculous patient, a reaction often followed. Prof. Moellgaard explained the reaction as due to the release of tuberculin formed by the destruction of tubercle bacilli in situ by the gold salt. To counteract these reactions he prepared an anti-tuberculin serum which he claimed protected both animal and patient from the tuberculin shock. His method of preparation of his serum was the same as others had used, and there was nothing new in his idea, as many immune sera have been prepared and have been abandoned as useless in tuberculosis therapy.

However, Moellgaard's announcement was received with due respect and specialists in practically all countries have given sanocrysin a fair trial. All reports so far fail to substantiate Moellgaard's claims. The tuberculin shock following the administration of sanocrysin is not due to tuberculin but to chemical poisoning quite similar to mercury poisoning. The stomatitis, dermatitis and nephritis which have been observed in patients treated with sanocrysin explain the phenomena of the so-called tuberculin shock.

While Moellgaard's claims have not been substantiated, sanocrysin has not been found to be valueless. Investigators are urging more time for study in the hope that new facts may come to light that will prove to be of value. This is a fertile field for investigation and much may come from it that will change our therapy in tuberculosis.

In conclusion, let me say, that there have been notable advances in diagnostic methods and in the therapy is the outstanding contribution in the last quarter of a century.

Programme

OF THE NORTHEAST MISSISSIPPI THIRTEEN COUNTIES MEDICAL SOCIETY HELD AT MACON, MISS., MARCH 21, 1933

Meeting called to order .... President F. L. McGahey
Invocation .... Rev. R. D. Pearson
Reading and Adoption Minutes Last Meeting
"Infantile Paralysis" .... Dr. E. Laurence Scott, Birmingham, Ala.
"Herpes Facialis with lesions in Gasserian and Merkel's Ganglion" .... Dr. J. G. Lilly, Tupelo
General Discussion.
"Tracing the Fraternal Concept to a Professional Attitude" .... T. H. Bayburn, Pontotoc
General Discussion.
"Cardiospasm" .... Dr. M. W. McRae, Corinth
General Discussion.

THE LIST
~~Mother~~
~~Betty~~
~~Jack~~
~~Jane~~
~~Grandad~~
~~Aunt Lil~~
Wm.

CHECK AND DOUBLE CHECK!!

to see if my doctor has paid his local Society dues.

Pre-operative Management of the Acute Surgical Abdomen*

BY DR. F. L. McGAHEY
Calhoun City, Miss.

In presenting this short paper I do not propose to go into a detailed discussion of the diagnosis and treatment of the various conditions that cause an acute surgical abdomen, but to outline roughly what Iconsider to be the best management of these cases from the time we, as general practitioners, see them till they are turned over to the surgeon. In referring to the acute surgical abdomen I have in mind especially such conditions as acute appendicitis, ruptured gastric or duodenal ulcer, intestinal obstruction, ruptured ectopic pregnancy, and cholecystitis as the most important. Acute specific infection of the tubes is not considered to be an emergency.

I am of the opinion that we do not need any better line of treatment than we have had for the past several years in order to materially reduce the present high mortality rate in acute surgical abdomens, but I do believe that we need a better understanding and co-operation on the part of the men who are doing general practice, into whose hands fully eighty-five per cent of these cases first fall.

I fully appreciate the fact that it is often impossible for our best diagnosticians, with their well equipped laboratories to make an accurate diagnosis of the exact pathological condition prior to operation, but when we stop to consider the fact that the treatment of all these conditions that give us the acute surgical abdomen is surgery and early surgery, then it seems to me that we should be satisfied if we are able to make a diagnisis of acute surgical abdomen and if we are able to make a differential diagnosis, so much the better.

The cardinal signs of acute surgical abdomen are pain, vomiting, rigidity, tenderness and pulse and temperature changes, with other signs and symptoms that come on after the early stage and of less importance.

After you have satisfied yourself that you have made a reasonably correct diagnosis of acute surgical abdomen, the first and most important thing to do at this time is to make your patient as comfortable as possible. Morphin in quarter to half grain doses is usually indicated but should not be given before a definite diagnosis is made. Counter irritation with spirits of cholorform will sometimes give a little temporary relief. Ice bags are of great benefit and especially if it is going to be several hours before you will be able to get the patient to a hospital and in the hands of a surgeon. All food should be withheld and if there is any one thing that should not be done it is this, "Do not give any purgatives of any kind," nor should any enemas be given. I am thoroughly convinced that one reason and the main reason for the increased mortality rate in cases of acute surgical abdomen is because the general practitioner, into whose hands these cases first fall, has never learned not to give a patient with acute abdominal pain a purgative. I don't think any patient who has an acute abdominal pain should be given any purgatives of any kind till acute surgical conditions of the abdomen have been ruled out.

I have never tried to do any surgery and never expect to and have no defense to offer for any surgeon but if we see one of these cases and give him temporary relief with narcotics, then give him a few horse doses of calomel or some other purgative and allow him to be fed and then give more opiates as needed to make him fairly comfortable and keep this procedure up for two, three or four days and then carry him to a surgeon and expect to get good results, we are oftentimes going to be sadly disappointed. I am ready to confess that I have been guilty of doing a little of this kind of practice but I am glad that I am able to tell you here and now that I am not doing that now. If I see a case that I think is an accute surgical abdomen, I do not give purgatives, enemas or food and if the condition has lasted for six or eight hours and he refuses to go to a surgeon or call in consultation, I frankly tell either the patient or his family or in some cases both that it is a case where surgery alone is indicated and that I can't do anything for him and that I am clearing myself of all responsibility.

I think we should talk over with these patients and their family the proposition of an operation either before or immediately after giving them a hypodermic, explaining to them in detail the dangers and complications that may arise as a result of delay. If my patient has as much as average intelligence I talk very freely and frankly with him, telling him as near as I can just what I think his condition is and especially explain to him why medical treatment is not indicated in his case and I find that almost one hundred per cent of them will submit to operation if properly handled. In almost all cases in negroes and in whites of low mentality there is no use to waste time trying to explain anything and I think the best thing to do in such cases is to tell them that they are going to die if they are not operated on and carry him on to a surgeon.

Some of these cases, especially those that are very sick and in extreme shock, should be transported in an ambulance and all of these cases that have to be transported any distance should be ambulance cases. We often find these cases out in the country where the roads are impassible and away from telephone service where we even have to haul them in wagons and in cases like this I think we should do everything possible to combat shock and at the same time get the patient to a hospital as soon as possible.

In conclusion I would say that it is not only the duty of a general practitioner to recognize the presence of an acute surgical abdomen but that it is also his duty to understand and insist that prompt surgical intervention is absolutely necessary. I had much rather have a beginner take out my appendix clean than to have a master surgeon after it had ruptured. In my opinion the acute surgical abdomen is purely a surgical condition yet the mortality rate is in direct ratio to the manner in which they are handled prior to operation which, in at least eighty-five per cent of cases, is determined by the general practitioners of the country.

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*Read before Staff Meeting, Houston Hospital, Houston, Mississippi, February 23, 1933.

When the general practitioners recognize the fact that the only treatment for the acute surgical abdomen is EARLY surgery, and that food and purgatives should not be given, then we are going to see a decided decline in the mortality rate in cases of acute surgical abdomen.

University of Tennessee

By J. S. Coe

The University of Tennessee operating on the quarter system graduates a class every three months —March 25th turned thirty more young doctors out on the public. Of these, seven were originally from Mississippi.

James Gordon Dees, son of J. T. Dees, of Philadelphia, Mississippi, rated well in his class and will serve an eighteen months interneship at the Memphis General Hospital. James Gordon received his premdical and literary education at the University of Mississippi and was a member of Theta Kappa Psi medical fraternity.

David W. Kennedy from Vicksburg, is a B. S. from Southwestern and a Theta Kappa Psi. He will interne at Shreveport General Hospital.

Hailing from Booneville is Bernard Patrick also a Theta Kappa Psi from the University of Mississippi. He is planning to return to his native heath and begin building a practice—even in these exacting times.

John C. Pearce, the rotund son of Dr. J. H. Pearce of Falkner, received his pre-medical training at University of Alabama and was affiliated with Theta Kappa Psi. He will interne at St. Josephs Hospital in Memphis.

Henry Sproles Provine, who is the son of Dr. J. W. Provine, President of Mississippi College, Clinton, is a Phi Chi and will interne at T. C. & I Hospital, Birmingham, Alabama.

From Meridian is Karl Otto Stingily, son of Dr. C. R. Stingily of the Stingily Laboratories, Meridian. Karl, also from the University of Mississippi, will nterne at the General Hospital, Little Rock, Arkansas.

Only one nurse was graduated from Mississippi— Mrs. Bertha Henshaw Williams, step-daughter of Mrs. T. R. Motley of Maud, Mississippi.

In the incoming section, we have only one Mississippi boy, Roy W. Hall, son of Dr. R. W. Hall of Clinton, Mississippi.

Tracing the Fraternal Concept To A Professional Attitude

BY T. H. RAYBURN, B.S.M.D.
Pontotoc, Miss.

Let us, that we may comprehend more fully, go back our respective ways and emerge again from that state of being that restricted our sense of environment only to a visual magnitude. Only then may we remember how elated, how shocked, how mysteriously surprised we were to find that we existed only as integral parts of a universe bounded by infinity.

Prepubertal conceptions not vain, we were then applied by organic mechanism to rising primordial instinct. We bridged the interval between pre and immediate post-pubertal influence and perceived, as from the annals of time, something of the infinite. Time relations persisted in wearying monotony. Hereditary instinct involved our being. Then power, until now latent, made itself manifest and we felt evolved from us something of aspiration, something of independence from hereditary character. We came slowly to grasp the significance of some Absolute Being, some hidden power of intangible resource. No less awed were we to find that each of us as individuals is representative of some periodic cycle of regenerative impulse, each in continuity with preceding like complexes.

Recurrent as is the broken chain of impulse in its intricate cycle, there is still in each repeating phase something that would link us with one continuous thought, one harmonious stimulus to one impelling force. Having come then to a realization of some power from behind, we became of the natural. It was not until then that each of us (although certain individual traits were manifest in the physical) in accord with previous experience, began to build in the direction of an ultimate universal concept. Our first effort, a vain attempt to secure a tangible relation between the material and the spiritual, lead us to our first and most definite realization of the interdependence of each of us as material beings. Until we did come to some conception of this relation between the finite and the infinite, we had not come to the fullest understanding of brotherhood. We thus having laid the background of the universal brotherhood, every individual of which is united by a bond of interest that would make of a more definite relation of what is and what is to be, we are in like manner come to our own more limited organization where we are again parts of an associated whole that bids for professional integrity. With anticipations of immortality are we greatly concerned, and we, as a means to that end, have come as a conclusion to our chosen profession.

We choose now to entertain all that goes for the enlightenment, for the betterment of each of us as carriers of the healing wand. We nave chosen, as a supplement to the fundamentals, a parallel to the great universal brotherhood. We must be eternally indebted to those before us who felt the need of an organization wherein members of the profession might assemble in discussion, wielding the wand of professional insight, and carrying with it the practical applications. Prmarily are we united in such organized relations for the purpose of promoting intellectual recourse, moral stability, and social impulse. We are no less concerned with the acquirement of a professional dignity, a professional diplomacy, and a spirit of service.

Once identified with organized medicine—the culmination of a life-time's dream—we find ourselves beginning to dream anew of the future realities, realities fashioned by precedent, guided by custom, and controlled by individual impulse. An impulse under which may beat a thousand woes, ten confidences, but a million joys, confidences reluctantly received by zealously guarded, the woes a contrast to our own puny ones, and the joys our compensation.

Under the light of Providence shall we be directed, guided to the one ultimate aim by the darkness we may dispel, and the cares we may displace. Serve nature in her needs, and by our own spirit instill the hope of eternity and the tranquility of dream and creation in our charges. Theirs shall be our beacon light to propel us to diligent, sincere, and skilled application of our science to their infirmities.

Feeling gentled but not subdued, we prepare to go our way silently proclaiming our creed, prepared to respond to even the humblest of our own "earth born companions and fellow mortals."

Ole Miss Medical News

By Woodard D. Beacham

ASHFORD HUNTER LITTLE, B.S., M.D.,
Professor of Physical Diagnosis and Medicine, and Associate Professor of Obsterics

Graduating from the University of Mississippi with the B.S. degree in 1920, Dr. Little received the degree of Doctor of Medicine from Tulane University of Louisiana in 1923. He accepted an Interneship at Hotel Dieu, New Orleans, which he held until beginning to serve as an interne in the Southern Pacific Railroad Hospital, Houston, Texas, a position which he filled until June, 1924.

On that date he returned to Mississippi, his native state, to act as House Surgeon at the Mississippi State Charity Hospital in Laurel.

In October, 1925, he removed to Oxford where he has resided since that time. Since living at the "home of Ole Miss," Dr. Little has been a member of the staff of the Oxford Hospital. In July of 1927, he did work in Urology in the Tulane Post-Graduate School at Charity Hospital in New Orleans.

Dr. Little accepted an Associate Professorship in Physical Diagnosis and Medicine at the University of Mississippi School of Medicine in September, 1928. He has held that postion since then. In August, 1930, he studied Allergy in the Balyeat Hay-Fever and Asthma Clinic, Oklahoma City, Okla.

He has been secretary of the North Mississippi Medical Society since 1927. Prominent in civic affairs, he is an outstanding member of the Rotary Club of Oxford. Fishing is his chief hobby and all forms of sports have a strong appeal to him. Dr. Little is affiliated with Nu Sigma Nu and Sigma Chi fraternities.

Resolution

North East Mississippi 13 County Medical Society assembled in first quarterly session at Macon, Miss., March 21, 1933.

Resolution: Subject, "The two year medical school at the University of Mississippi."

Whereas: The two year medical school at the University of Mississippi is one of the most thorough in the United States as proved by the grades made by its graduates when they go to other schools for their junior and senior years, by their work as internes, by their high grades made on state examinations for licenses, and by their efficiency and resourcefulness in practice.

The greatest endowment a medical school can have is its teaching staff. In this Ole Miss Medical department has a strong fort. It points the student to the right view point. It instills right principles. It gives the student a vision. It teaches the student that he must win by hard work and by merit. It brings up all the sides needed to make a strong and useful practitioner.

With its present buildings and equipment this school has turned out a class of men who have not been excelled in this nation. It can continue to do so. It is positively no time to demand more buildings and more equipment generally speaking. The world must learn to do with less. Medical students should not be taught into helplessness by too much equipment. This may be the cause of the dearth of doctors now in the rural communities and the overflow in the cities. Let Ole Miss Medical School continue to demonstrate to the world what can be done with a reasonable amount of funds. When it fails to do this it will be time enough to put its head on the chop block.

It is the type of man that counts for the most in the practice of medicine. We must not rule out the poor boy of which we have many. We must keep our two year course so that we may discover and give a start to the young man with a natural professional mind, a medical soul, and a missionary heart. This type of young man the medical profession needs to day worse than it does stone buildings and marble floors.

Merit should always be rewarded. As long as the Ole Miss Medical School, the two year course, turns out the type of men it has and is now, it is unjust, unfair, and "uneconomical" to destroy it.

We therefore urge that every local society within our confines and the State Medical Association join us in urging our Governor, our State Board of Trustees, and the National Medical Council to place our two year medical school back in regular standing and let it alone and quit asking for more money and more equipment until financial conditions improve and until this school fails to do work equal to any other medical school in the United States.

Committee:
Doctors: W. H. ANDERSON, Chairman,
J. M. ACKER, JR.
M. Q. EWING.

Dr. R. S. Kirk

On the evening of February 11th, 1933, Dr. R. S. Kirk of Amory, died at the Baptist Hospital in Memphis. The cause of death was carcinoma of the cecum. He had not been well for a considerable time—had undergone a "first-step" operation a short time before his death, but he did not recuperate sufficiently to have the "second-step" of the operation done. His remains were brought home on the day following his death and he was buried on the afternoon of Febuary 13th, in Masonic Cemetery in Amory. His was the largest funeral attendance ever held in Amory. Dr. Kirk was the oldest physician in Monroe county, both in years of life and practice. In all probability he had rendered professional service to more people than any man who ever practiced in the county, and possibly was the most poorly paid in proportion to the work done. That is to say, most poorly paid in money. But no man ever had more friends (for all who knew him were his friends) or was more devotedly loved by his clientele. He is, and will long be, missed, not only by his family, but by the community in which he had lived so long and labored so faithfully.

Therefore, be it resolved by the North East Mississippi Thirteen Counties Medical Society, that in the death of Dr. Kirk, the society has lost a member whose life was an honor to the profession and an inspiration to all medical men who knew him.

Be it further resolved that this soiciety goes on record as greatly appreciating the splendid life of service he gave to humanity and deeply regretting his death.

Be it further resolved that this society extends its deep and sincere sympathy to his friends and sorrowing family.

(Signed) NORTHEAST MISS. 13 COUNTY MEDICAL SOCIETY.

Medical Society Meets

NEW ALBANY, Miss., March 23.—The quarterly meeting of the North Mississippi Medical Society was held here this afternoon at the Baptist Church. Seventy-five doctors from north Mississippi and from Jackson and Memphis, Tenn., were in attendance. Some of the town represented were: Tupelo, Holly Springs, Water Valley, Corinth, Oxford, Okolona, Aberdeen, Ripley, Blue Mountain and Pontotoc.

The following subjects were discussed: "A Motion Picture Study of the Heart in Health and Disease," Dr. Lyle Motley, Memphis; "Umbilical Hemorrhage," Dr. R. G. Grant, Holly Springs, with discussion opened by Drs. C. M. Murry and R. J. Criss; "Childhood Type Tuberculosis," Dr. W. A. Tooner, Tupelo, with discussion opened by Drs. N. G. Gholson and F. E. Linder; "Diphtheria," Dr. I. B. Trapp, New Albany, with discussion opened by Drs. D. C. French and R. M. Adams; "Special Feature—"Thirty Minutes of Thrills," a fishing motion picture.

The business session was held after the completion of the program.

Officers of the Medical Society are Dr. G. A. Brown, Water Valley, president and Dr. A. H. Little of Oxford, secretary.

Letters to the Editor

Dr. W. H. Anderson
Booneville, Miss.
My dear Dr. Anderson:

Several months ago I wrote you a "Depression Bitten Letter." Today I am mailing you a sequel—a poem, the author unknown, but evidently by a man who knowns.

"THIS MAN REALLY KNOWS"

"Absolute knowledge have I none,
But my aunt's washer-woman's sister's son,
Heard a policeman on his beat,
Say to a laborer on the street,
That he had a letter just last week,
Written in the finest Greek,
Of a colored man in a Texas town,
Who got it straight from a circus clown,
That a man in the Klondike heard the news,
From a gang of South American Jews,
About somebody in Borneo,
Who heard a man who claimed to know,
Of a swell society Madamoiselle,
Whose mother-in-law knows certainly well,
That her seventh husband's sister's niece,
Has stated in a printed piece,
That she has a son who has a friend
Who knows when this depression is going to end."

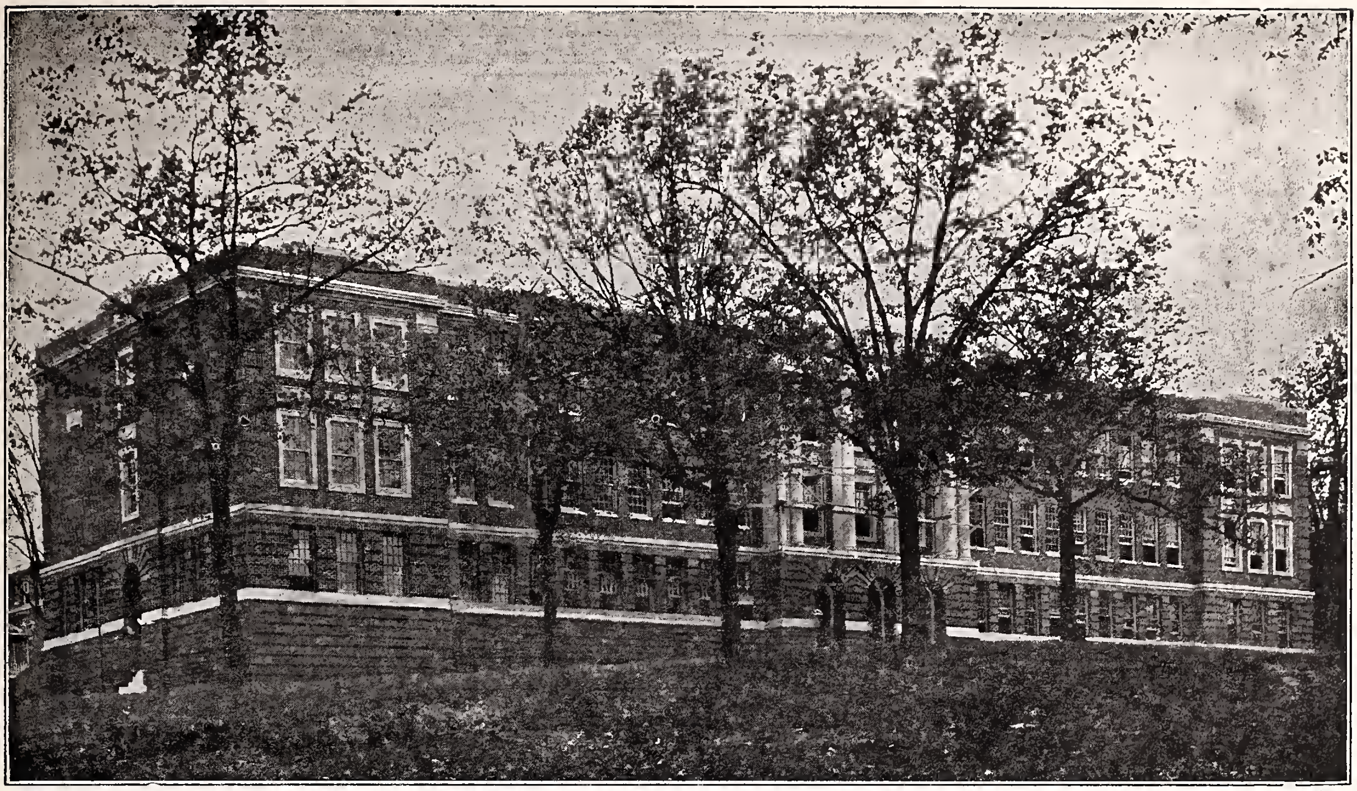
I may write you again after Roosevelt has "fixed" everything.

Sincerely yours,
E. M. HOLDER.

We thank you Doctor Holder, you are a man of few words but much wisdom. We know that you know that the son's friend knows. But if there should be any slip about it in any way, have him subscribe for The Mississippi Doctor in which he will find the entire matter explained fully. Any time you catch the low down on any important social or economical question of human interest passing over the mental wires please do as you have been doing, rush it to The Mississippi Doctor for further consideration.—Ed.

Two men were seated in a crowded tram car. One, noticing that the other had his eyes closed, said, "Bill, ain't you well?"

"I'm all right," said Bill, "but I do 'ate to see ladies standing."—Dartford Chronicle.



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